Select Committee on Affordable Health Care for Floridians

Public Hearing

November 4, 2003
3:00 – 7:00 PM
Tampa, Florida

Revised

Johnnie Byrd
Speaker

Frank Farkas
Chair

House of Representatives

Select Committee on Affordable Health Care for Floridians

PUBLIC HEARING AGENDA

November 4, 2003
3:00 – 7:00 PM
H. Lee Moffitt Cancer Center & Research Institute
Stabile Research Building Auditorium
Tampa, Florida

THEME: **Discussion of the Challenges of the Individual Market, Medical Savings Accounts, Health Reimbursement Accounts, High Deductible Plans, and Out-of-State Groups**

3:00 - 3:15	Opening Remarks by Chair Frank Farkas Greetings from Dr. Pledger, Deputy Director, Moffitt Cancer Center
3:15 – 3:30	Peter Nolan, Consultant Employers Purchasing Alliance
3:30 – 3:45	Dr. Frank M. Brocato President and CEO Health Care Coalition
3:45 – 4:00	Mike Hampton, Public Policy Specialist Government Relations Department Golden Rule Insurance
4:00 – 4:15	William O'Connor, Vice President Government Relations and Regulatory Affairs UICI J.P. Wieske, Director State Affairs Council for Affordable Health Insurance (CAHI)
4:15 – 5:00	Questions and Answers
5:00 – 5:15	BREAK
5:15 – 7:00	**Public Testimony**

210 House Office Building, 402 South Monroe Street, Tallahassee, Florida 32399-1300 (850) 487-3771

Peter Nolan
Employers Purchasing Alliance

Dr. Frank M. Brocato
Health Care Coalition

Mike Hampton
Golden Rule Insurance

Mike Hampton, FLMI, ALHC

Mike Hampton is a Public Policy Specialist in the Government Relations Department for Golden Rule Insurance. In that role, Mike has coordinated Golden Rule's Government Relations efforts in Colorado, Connecticut, Kentucky, Iowa and Maryland. He recently took over the responsibilities for Florida. Mike began his career with Golden Rule in 1988 as a Health Underwriter Trainee; a role in which he evaluated health insurance applicants for their insurability. During his 15 years with the company, Mike has also held positions in the Marketing/Product Management Department, and the Compliance/Product Development areas. He has also assisted in the Claims, New Business and Client Services Departments.

Mike holds the designations, Fellow, Life, Management Institute, and Associate, Life and Health Claims. He is a past president for the Indianapolis FLMI Society, a society of Indianapolis insurance professionals, and has recently been named to the Board of the Maryland Health Insurance Plan (MHIP). He resides in Avon, Indiana with his wife, Mary, who also works for Golden Rule as a Trainer, and his daughters, Lindsey, 8 and Brookelyn, 5.

Golden Rule Insurance

Michael Hampton, FLMI, ALHC
Government Relations

Golden Rule Insurance

- Active in the health insurance market for 60 years
- AM Best "A" Rated
- Named to Ward's 50 as one of the 50 best managed life and health insurance companies in the areas of safety, consistency and performance.
- Insures approximately 50,000 Florida residents in the health insurance market for individuals and Medicare Supplement Markets.
- Offers innovative products in the individual and small group, and individual life insurance markets.

Golden Rule Insurance

- Has either created or been one of the first carriers to market the following products:
  - Inflation Guard major medical insurance.
  - Short-term major medical insurance.
  - Medical Savings Accounts.
  - Life insurance products and annuities designed to fund long-term care benefits.

Golden Rule Insurance

- Dedicated to developing creative market reforms and regulatory reforms to ensure that affordable products are available in the individual marketplace including:
  - High Risk Pools.
  - Loss Ratio Guarantee.
  - Medical Savings Accounts.
  - Tax Credits for individuals.

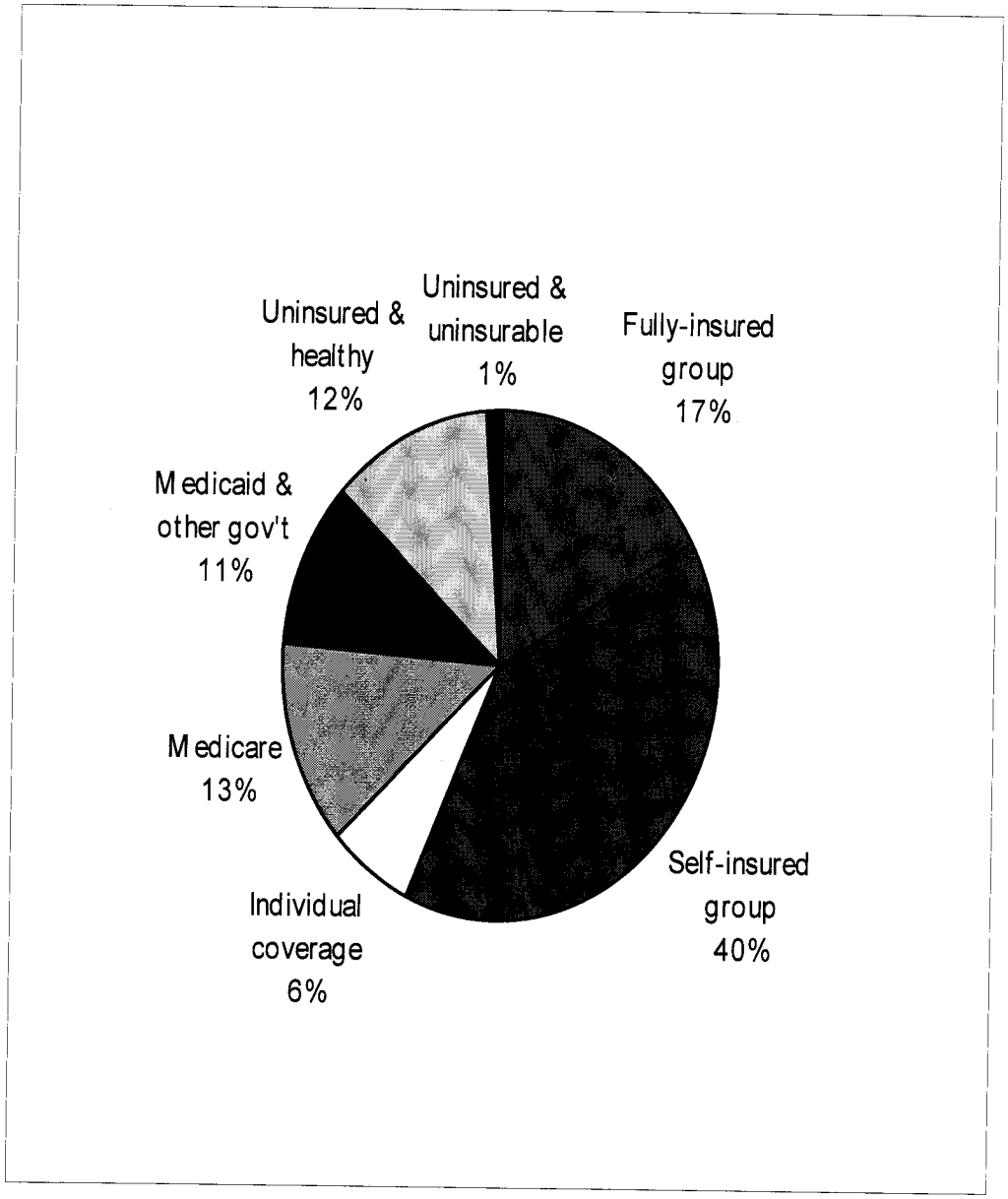
Market for Individuals

Products for Individuals Without Access to Employer Provided Coverage.

Characteristics of the Market for Individuals

- Very small. Only 6% of the population in the United States is covered in the individual market.

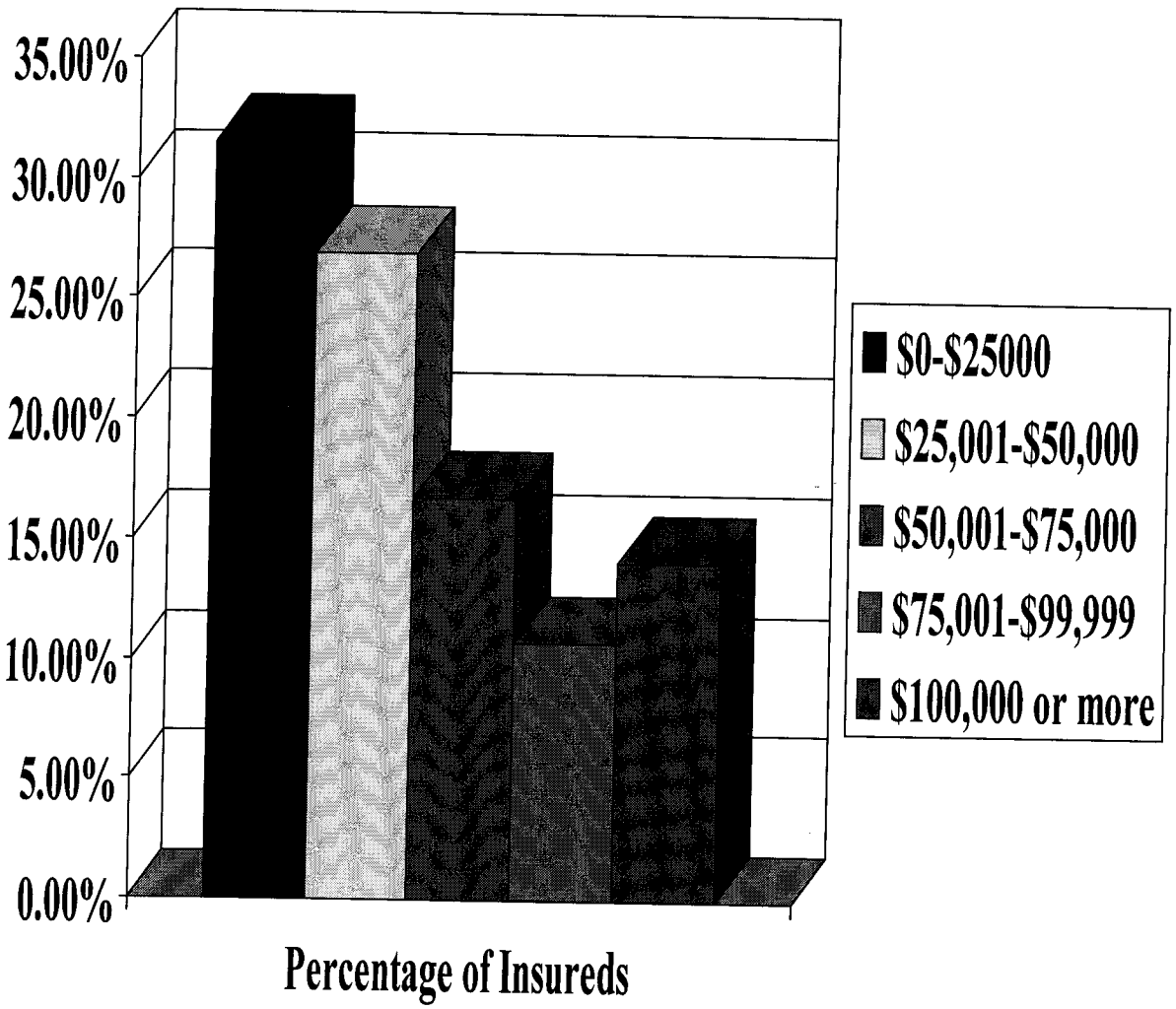
Health Insurance Coverage in the United States



Characteristics of the Market for Individuals

- Very small, only 6% of the population in the United States is covered in the individual market.
- Price Sensitive. Individuals are relatively low-income (30% make less than $25,000) and receive few tax benefits, unlike employer provided coverage.

Income of Individuals Purchasing Golden Rule Coverage



Characteristics of the Market for Individuals

- Very small. Only 6% of the population in the United States is covered in the individual market.
- Price Sensitive. Individuals are relatively low-income (30% make less than $25,000) and receive few tax benefits, unlike employer provided coverage.
- Individuals covered for a relatively short time.

Individual Market Retention

- Average length of time an individual is covered by a Golden Rule plan is between three and four years.

Characteristics of the Market for Individuals

- Very small. Only 6% of the population in the United States is covered in the individual market.
- Price Sensitive. Individuals are relatively low-income (30% make less than $25,000 per year) and receive few tax benefits, unlike employer provided coverage.
- Individuals covered for a relatively short time .
- Three categories of individual insureds.

Categories of Coverage in Market for Individuals

Category	Age	Occupations	Product Need	Budget
Young Singles	20-40	Employed Self-employed Unemployed	Routine care coverage	$50-150 per month
Middle Age Families	30-50	Self-employed Employed	Limited out-of-pocket risk	$200-400 per month
Pre-retirement with no children	45-65	Employed Self-employed Unemployed	Low-cost catastrophic	$100-200 per month

Characteristics of the Market for Individuals

- Very small. Only 6% of the population in the United States is covered in the individual market.
- Price Sensitive. Individuals are relatively low-income (30% make less than $25,000 per year) and receive few tax benefits, unlike employer provided coverage.
- Individuals covered for a relatively short time .
- Three categories of individual insureds.
- 90% of those that apply for individual coverage can obtain coverage.

Golden Rule Products

Products Golden Rule Offers

- Plan 80. Traditional High Deductible with 80/20 Coinsurance.
- Plan 100. High Deductible with No Coinsurance.
- Basic Plan. Basic Hospital/Surgical Coverage.
- Copay Plan. Lower Deductible with various copay levels for routine office visits.
- Medical Savings Account. High Deductible Plan combined with a Savings Account.

Plan	**Plan 100®**	**Plan 80℠**	**Basic Plan℠**
Type	• PPO or Non-PPO	• PPO or Non-PPO	• PPO or Non-PPO
Deductible Options (maximum 2 per family, per year)	• $1,000 • $2,500 • $1,500 • $5,000	• $1,000 • $2,500 • $1,500 • $5,000	• $500 • $1,500 • $5,000 • $1,000 • $2,500
Coinsurance Options (per covered person, per calendar year)	• 100%	• 80/20 to $5,000, then 100%	• 80/20 to $10,000, then 100%
Doctor Office Visit Fees	• 100% After Deductible	• 80% After Deductible	• Not Covered
Outpatient X-Ray and Lab	• 100% After Deductible	• 80% After Deductible	• 80% After Deductible for MRI and CAT Scans • 80% After Deductible for Other Tests Performed Within 14 Days of Surgery or Confinement
Preventive Care, Including Routine Physicals and Lab Fees ($150 maximum per year after 12 months for each adult 19 or older)	• 100% After Deductible	• 80% After Deductible	• Not Covered
Mammography, Pap Smear, and PSA Testing	• 100% After Deductible	• 80% After Deductible	• 80% After Deductible
Outpatient Rx	• 100% After Deductible	• 80% After Deductible	• Not Covered
Inpatient Hospital and Surgical Fees, Outpatient Surgery, and Other Covered Inpatient and Outpatient Fees	• 100% After Deductible	• 80% After Deductible	• 80% After Deductible
Emergency Room Fees	• 100% After Deductible	• 80% After Deductible	• See Plan Provisions.
Initial Rate Guarantee (subject to benefit and address changes)	• 12 months	• 12 months	• 12 months
Lifetime Maximum (per covered person)	• $3 million	• $3 million	• $3 million
Optional Benefits (click here for full listing)	• Maternity • Supplemental Accident • Term Life Rider • Prescription Drug Card	• Maternity • Supplemental Accident • Term Life Rider • Prescription Drug Card	• Maternity • Supplemental Accident • Term Life Rider

Plan	**Copay 25SM Plan**	**Copay 35SM Plan**	**Copay 45SM Plan**
Type	• Full PPO Required (see PPO on this page)	• Full PPO Required (see PPO on this page)	• Full PPO Required (see PPO on this page)
Deductible Options (maximum 2 per family, per year)	• $500 • $750 • $1,250	• $500 • $750 • $1,250	• $500 • $750 • $1,250
Coinsurance Options (per covered person, per calendar year)	• 80/20 to $10,000, then 100% • 70/30 to $10,000, then 100% • 50/50 to $8,000, then 100%	• 80/20 to $10,000, then 100% • 70/30 to $10,000, then 100% • 50/50 to $8,000, then 100%	• 80/20 to $10,000, then 100% • 70/30 to $10,000, then 100% • 50/50 to $8,000, then 100%
Doctor Office Visit Fees	• $25 Copay, then 100% for history and exam	• $35 Copay, then 100% for history and exam	• $45 Copay, then 100% for history and exam
Doctor Office X-Ray and Lab (performed in the Doctor's office on the same day as a visit)	• $25 Copay, then 100%	• $35 Copay, then 100%	• $45 Copay, then 100%
Preventive Care, Including Routine Physicals and Lab Fees ($150 maximum per year after 12 months for each adult 19 or older)	• See Doctor Office Visit Fees and Doctor Office X-Ray and Lab	• See Doctor Office Visit Fees and Doctor Office X-Ray and Lab	• See Doctor Office Visit Fees and Doctor Office X-Ray and Lab
Mammography, Pap Smear, and PSA Testing	• Copay benefits in Doctor's Office; deductible and coinsurance elsewhere	• Copay benefits in Doctor's Office; deductible and coinsurance elsewhere	• Copay benefits in Doctor's Office; deductible and coinsurance elsewhere
Outpatient Rx	• Generic -- $20 copay • Name-brand -- $50 copay after a $250 calendar-year, per person deductible	• Generic -- $20 copay • Name-brand -- $50 copay after a $250 calendar-year, per person deductible	• Generic -- $20 copay • Name-brand -- $50 copay after a $250 calendar-year, per person deductible
Inpatient Hospital and Surgical Fees Included on the Hospital Bill	• $500 Copay, then Coinsurance (maximum 2 copays per person, per year)	• $750 Copay, then Coinsurance (maximum 2 copays per person, per year)	• $1,000 Copay, then Coinsurance (maximum 2 copays per person, per year)
Outpatient Surgery and Other Covered Inpatient and Outpatient Fees	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance
Emergency Room Fees	• Deductible and Coinsurance	• Deductible and Coinsurance	• Deductible and Coinsurance

Plan	**MSA 100® Plan**	**MSA 80SM Plan**
Type	• PPO or Non-PPO	• PPO or Non-PPO
Deductible Options	• For details, please contact Golden Rule through our Consumer Information or Broker Information pages.	• For details, please contact Golden Rule through our Consumer Information or Broker Information pages.
Coinsurance Options	• 100%	• 80%
Doctor Office Visit Fees	• 100% After Deductible	• 80% After Deductible
Outpatient X-Ray and Lab	• 100% After Deductible	• 80% After Deductible
Preventive Care, Including Routine Physicals and Lab Fees ($150 maximum per year after 12 months for each adult 19 or older)	• 100% After Deductible	• 80% After Deductible
Mammography, Pap Smear, and PSA Testing	• 100% After Deductible	• 80% After Deductible
Outpatient Rx	• 100% After Deductible	• 80% After Deductible
Inpatient Hospital and Surgical Fees, Outpatient Surgery, and Other Covered Inpatient and Outpatient Fees	• 100% After Deductible	• 80% After Deductible
Emergency Room Fees	• 100% After Deductible	• 80% After Deductible
Initial Rate Guarantee (subject to benefit and address changes)	• 12 months	• 12 months
Lifetime Maximum (per covered person)	• $3 million	• $3 million
Optional Benefits (click here for full listing)	• Supplemental Accident • Term Life Rider • Hospital Indemnity Rider	• Supplemental Accident • Term Life Rider • Hospital Indemnity Rider

Medical Savings Accounts
(for the self-employed)

Effective Date
• Tax years beginning after December 31, 1996

Eligible
• Self-employed, covered under qualified major medical, and not covered by other health insurance

MSA Contributions
• MSA contributions are 100% tax-deductible from net income

Health Premium
• 100% tax-deductible in 2003

Medical Withdrawals
• Tax-free

Interest Earned
• Tax-deferred; if used for qualified medical expenses, tax-free

Nonmedical Withdrawals
• Income tax +15% penalty tax (under age 65)
• Income tax only (over age 65)

Death, Disability
• Income tax only

Deductible and out-of-pocket maximums may be adjusted annually based on changes in the Consumer Price Index.

This is only a brief summary of the applicable federal law. Consult your tax attorney, accountant, or other qualified advisor for more details.

Deductibles and Monthly MSA Deposit Options

	Singles		*Families*	
Deductible	$1,700	$2,500	$3,350	$5,050
80% Plan out-of-pocket max. (in addition to deductible)	$1,500	$750	$2,500	$1,000
Maximum Monthly Deposit (Legal Limit)	$92.08	$135.41	$209.37	$315.62

Golden Rule MSA Management
(available only for self-employed applicants)

One-Time Set-Up Fee	*Monthly Maintenance*	*Minimum Monthly Deposit*	*Current Interest Credited*
$10	$3	$25	4%

As custodian, Golden Rule is responsible for the money in your Medical Savings Account. We have chosen The Northern Trust Company, a Chicago-based bank, as our agent to administer your MSA.

You will receive an MSA checkbook from The Northern Trust Company shortly after your qualified major medical becomes effective. ***MSA Withdrawals*** are made by simply writing a check.

MSA Deposits are set up on the same payment plan as premiums for the major medical. Lump-sum deposits are also accepted; however, you must continue to deposit the $25 monthly minimum with your premium payment.

You will receive quarterly statements itemizing account deposit and withdrawal activity.

If you prefer, you can purchase the qualified major medical from Golden Rule and set up your savings account with another qualified custodian.

Benefits of Golden Rule's MSA

MSA checkbook.
Golden Rule's MSA provides a checkbook shortly after the plan becomes effective. Medical expenses are paid by simply writing a check.

Interest on the first dollar.
Interest earnings begin with the first dollar -- no minimum balance required.

Quarterly statements.
An account activity report -- contributions, withdrawals, interest -- will be provided on a quarterly basis.

Control!
You make all the decisions concerning the savings account. Golden Rule doesn't come between you and your money.

Go back to ***MSA Plans***

Marketing Methods Golden Rule Utilizes

- Internet Marketing.
- Sponsored Marketing.
- Brokerage Force.
- General Agents.
- Direct Sales.

Sponsored Marketing Arrangements

- ING
- Allstate
- Ameri-Life
- Cotton States
- GE Financial
- Gen America Financial
- Horace Mann
- Life of Georgia
- Lincoln Financial
- Mass Mutual
- Metropolitan Life
- Modern Woodmen
- MONY
- Nationwide
- New England Life
- Rural Insurance (Farm Bureau)
- Shelter Insurance
- Signator
- Western-Southern Life
- World Financial Group

Keys to a Healthy Market for Individuals

- Rating and Underwriting Flexibility.
- Reasonable Administrative Requirements.
- Viable High Risk Pool with adequate funding.
- Quick Product Implementation.
- Tax Credits or other funding mechanisms for the individual market.

Rating and Underwriting Flexibility

- Some states have destroyed their markets by limiting carriers ability to underwrite or rate individuals with preexisting conditions. These states include: ME, MA, NJ, NY and VT. States such as KY, NH and WA have repealed disastrous reforms in an attempt to bring carriers back to their markets (with mixed results).
- These reforms have led to unaffordable health insurance premiums.

Guaranteed Issue Community Rating

THE DISASTROUS CONSEQUENCES

THE PROBLEM:

Several states have enacted guaranteed issue and community rating with disastrous consequences. When Congress passed HIPAA in 1996, guaranteed issue was imposed on the small group market.

Guaranteed issue means anyone can buy health insurance at any time, regardless of the person's health. This is the equivalent of insuring your home after the fire has already started.

Community rating means that everyone pays the same rate, regardless of their age. So with community rating, a 23-year old pays the same rate as a 64-year old.

These provisions -- guaranteed issue and community rating -- have ravaged Colorado, Maine, Massachusetts, New Jersey, New York, and Vermont. As a result, consumers are left with higher prices and fewer choices.

COLORADO

"Rate hikes of 40 to 50 percent are commonplace, causing 85,000 Coloradoans to lose small group coverage last year."

-- Spencer Swalm, employee benefit consultant, Health Care News, September 2002

MAINE

Monthly Rate for Family Plan (November 2002)

Blue Cross/Blue Shield $1,192 for a $500 deductible plan

Anthem Health Plans of Maine (Blue Cross/Blue Shield) is the only company left in the individual health insurance market (down from 10 carriers before guaranteed issue and community rating passed). Anthem has been forced to raise rates 67% since 1998.

Sources: White Paper: Maine's Individual Health Insurance Market, Maine Bureau of Insurance, January 22, 2001

Guaranteed Issue

Community Rating

MASSACHUSETTS

Monthly Rates for a Family Plan (November 2002) (35 year-old husband, wife, and 2 children)

Company Name	Type of Plan	Boston	Springfield
Aetna Life	PPO	$2,007.06	$1,893.45
Aetna Health	HMO	$1,474.70	$1,182.10
Blue Cross/ Blue Shield	PPO -- $250 deductible	$1,001.99	$882.49
Blue Cross/ Blue Shield	HMO -- Standard	$794.49	$699.74
CIGNA	HMO	$1,301.43	$1,217.79
Fallon Community Health Plan, Inc.	HMO	$1,073.75	Not available
Gerber Life	Medical Plan	$2,898.82	$2,810.59
Guardian	PPO Medical	$1,698.66	$1,294.05 $1,289.80
Harvard Pilgram	HMO -- Standard	$881.86	$935.86
Health New England	HMO	Not available	$857.24
John Alden	PPO	$1,576.61	$1,254.95
Mega Life	Medical Plan	$2,586.22	$2,230.66
New England Life	PPO	$1,890.15	$1,819.07
Tufts	HMO	$1,198.13	$1,198.13
United Health	PPO Medical Plan HMO	$1,657.04 $2,181.02 $1,093.69	$1,657.04 $2,181.02 Not available

Source: Massachusetts Division of Insurance

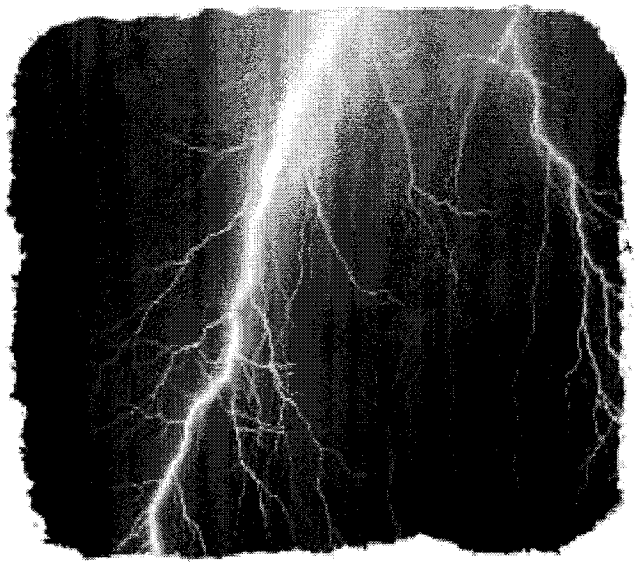
NEW JERSEY

Monthly Rates for Family "Plan D" Plans
(November 2002)

	$500 Deductible
Aetna Life Insurance Company	$5,855.00
Celtic Insurance Company	$11,218.00
Fortis Insurance Company	$17,356.00
Fortis Insurance Company (PPO)	$13,884.00
Guardian	$4,687.00
Guardian PPO North (except Hunterdon)	$4,900.00
Guardian PPO South (except Salem)	$4,746.00
Horizon Blue Cross Blue Shield of NJ	$3,478.34
National Health Insurance Company	$5,683.00
Oxford Health Insurance Company	$3,418.97
Trustmark Ins. w/o optional ABMT	$17,550.00
Trustmark Ins. w/optional ABMT	$18,427.50
United Health Care Ins. Co	$5,331.40

Since guaranteed issue and community rating passed, the number of people covered has dropped by more than 40%.

Sources: New Jersey Department of Insurance and New Jersey Individual Health Coverage Program



NEW YORK

Monthly Rates for a Family Plan (November 2002)
(35-year old husband, wife, and 2 children)
Essex County -- low cost county (Lake Placid)

Capital District Physicians Health Plan	$1,044.39
Empire Health Choice, Inc. -- HealthNet	$889.52
HMO Blue	$1,048.50
HMO of Blue Shield of Northeastern New York	$1,028.93

Monthly Rates for a Family Plan (November 2002)
(35-year old husband, wife, and 2 children)
Westchester County -- high cost county (Chappaqua)

HIP	$1,396.71
GHI HMO	$1,396.18
Horizon	$1,392.00
United Health Care of New York	$1,365.17
CIGNA	$1,304.52
HealthNet of New York	$1,300.07
Magna	$1,295.00
Empire	$1,186.04
AmeriHealth Health Plan	$1,182.10
Aetna	$1,158.10
Oxford	$1,132.99

Source: New York Department of Insurance

VERMONT

Monthly Rates for a Family Plan (November 2002)

Blue Cross/ Blue Shield	$652.54 for a $3,000 deductible plan
MVP Health Plan	$1,210.57 for a $25 copay plan
Mutual of Omaha	$344.14 for a $3,500 deductible plan $233.40 for a $10,000 deductible plan

Source: Vermont Department of Insurance

COST SUMMARY

Cost of Health Insurance for a Family[1]
Guaranteed Issue States

Location	Monthly Cost	Type of Plan
Maine	$1,192	$500 deductible
Massachusetts	$1,001	PPO
New Jersey	$5,855	$500 deductible
New York	$1,132	HMO
Vermont	$1,210	HMO

[1]*Sources: See inside for details*

Cost of Health Insurance for a Family[2]
Non-Guaranteed Issue States

Location	Monthly Cost	Type of Plan
Chicago, Illinois	$288.77	$1,000 deductible
Dallas, Texas	$302.06	$1,000 deductible
Easton, Pennsylvania	$202.00	$1,000 deductible
Indianapolis, Indiana	$214.83	$1,000 deductible
St. Louis, Missouri	$276.00	$1,000 deductible

[2]*Source: ehealthinsurance.com*

Health insurance is affordable in states that have health insurance safety net plans, which provide affordable health insurance to people who are sick. Without the safety nets, these individuals would be left out of the health insurance system. Guaranteed issue was supposed to help sick people get health insurance, but it has the unintended consequence of increasing the cost of health insurance.

Reasonable Administrative Requirements

- Some states have enacted administrative requirements that add considerable costs to health insurance coverage or create a market that is harmful to the consumer. Including:
  - Onerous Clean Claims standards in KY and TX.
  - Onerous notice requirements such as the health benefit plan description form in CO.
  - Requirement that carriers offer only standardized plans or standardized plans in addition to carrier designed plans (MA and NJ and repealed in several other states).

Viable High Risk Pool with Adequate Funding

- 30 states have enacted high risk pools.
- Four states have expanded or enacted high risk pools in response to disastrous reforms (KY, NH, SD and WA).
- Funding mechanisms should be broad based. Everyone benefits from a viable high risk pool: if uninsured, uninsurable citizens have access to a high risk pool, it will reduce uncompensated care costs.
- Costs are minimal, usually less than $1 per covered individual/per month.
- Federal funds are available to subsidize a small portion of the losses.
- Can be used to cover HIPAA eligible individuals.
- Best way to ensure guaranteed access to coverage without making the general individual market unaffordable.

Quick Product Implementation

- Association Group Plans are regulated in several different ways in the states including:
  - Reasonable regulation, once the product is approved in home state, it is available to offer in the issue state (AZ, IA, MD, MI, MS, NE, PA, TN and VA).
  - Reasonable regulation, such as a Certification filing for forms (GA and CO), and/or an informational filing for rates with specific information requiring to be filed (CO).
  - Overregulation.

Tax Credits or Other Funding Mechanisms for the Individual Market.

- Individuals without access to employer coverage have minimal tax benefits to encourage them to purchase coverage.
- Golden Rule supports Fair Care Legislation in Congress.
- State could make changes to small group law to allow for list billing.

Fair-Care

H.R. 583 -- Reps. Mark Kennedy (R-MN) & William Lipinski (D-IL)
S. 1570 -- Sens. Rick Santorum (R-PA) & Lindsey Graham (R-SC)

It's time to treat everyone fairly.

Health insurance certificates for 41 million uninsured Americans.

Who's eligible?

- Individuals who don't have access to employer-provided health insurance.
- Individuals who aren't enrolled in a government health insurance program.

How much is the health insurance certificate?

- $1,000 for individual
- $2,000 for husband/wife or single mother
- $3,000 for family

Q. Can the health insurance certificate be signed over to an insurance company?

A. Yes. You can sign your monthly allotment over to the insurance company of your choice.

Q. Is $3,000 enough for a family to buy health insurance?

A. Yes. $3,000 will be enough for any family to buy health insurance coverage. If the insurance plan costs more, they can add some of their own money. Currently Aetna and the Western Growers Association have a new medical plan that costs less than $3,000 a year for family coverage.

Q. If I lose my job and I am temporarily uninsured, would I qualify for the health insurance certificate?

A. Yes.

Q. Do I pay taxes on the health insurance certificate?

A. No. The health insurance certificate is completely tax free.

Q. Can I switch health insurance plans during the year and still keep the health insurance certificate?

A. Yes. You can switch plans at any time during the year and still keep the certificate. If you even switch insurance companies, you can sign your certificate over to your new company.

Q. What kind of health insurance can I buy?

A. You can use your health insurance certificate for any health insurance plan you want. You can buy a fee-for-service plan, a PPO, HMO, or MSA. Insurance companies will probably develop new products, such as Aetna's new medical plan.

Q. Will I get more money next year?

A. Yes, each year your family will get $3,000 for you to buy health insurance.

Q. I work for a company that offers health insurance, but I don't accept it because it is too expensive. Can I have a health insurance certificate?

A. Unfortunately, you would not be eligible for a health insurance certificate because you work for a company where health insurance is offered.

List Billing

- Would allow individual health insurance companies to market to an employer that does not provide health insurance coverage.
- The carrier would market their individual plans to the employees.
- The insurance company would bill the employer, who would, in turn, payroll deduct the premiums from the employees' paychecks.
- The employer could set up a section 125 plan to payroll deduct the premiums on a pre-tax basis, causing substantial tax savings (20% of the health insurance premium or higher) for the employee.

William O'Connor
UICL

J.P. Wieske
Council for Affordable Health Ins.

Background Matieral

Issue Brief
Findings from HSC

THE INDIVIDUAL HEALTH INSURANCE MARKET:

Researchers, Policy Makers Seek Common Ground on Tax Credits for the Uninsured

As policy makers in Washington consider the use of tax credits to encourage uninsured Americans to buy health insurance, researchers and policy experts debated the merits of the individual health insurance market at a conference sponsored by the Center for Studying Health System Change (HSC) and Health Affairs. *One presenter estimated that the individual market "works acceptably well for about 80 percent of potential buyers" but is unlikely to help the remaining 20 percent, who suffer from the worst health. Another presenter argued that the individual market "is not a good place to target substantial new resources aimed at lowering the number of uninsured persons." A proposal that intrigued many conference attendees is to have the federal government serve as a reinsurer of the individual market "by assuming responsibility for most of the costs of people in the highest 2 percent to 3 percent of the national spending distribution."*

Growing Interest in Health Insurance Tax Credits

Tax credits to help people buy individual or nongroup health insurance are a key part of the national debate over how to reduce the number of uninsured Americans. President Bush and members of Congress from both political parties have proposed tax credits for low-income individuals and families, but reliance on the individual market has drawn sharp criticism from those who believe the market is badly flawed and is not the best avenue for expanding coverage. On October 23, HSC and *Health Affairs* sponsored a conference to explore divergent views on the individual market and policy options for a tax credit approach. *Health Affairs* also published a special online issue examining these questions.[1]

Reflecting the keen interest in this topic on Capitol Hill, the conference drew a standing room only audience of almost 300 analysts. The objective of the meeting, HSC President Paul B. Ginsburg said, was "to dig beneath the surface and explore what we know, what we don't know and what we need to find out about this market."

The 108th Congress is certain to focus renewed attention on individual tax credits. House Speaker Dennis Hastert (R-Ill.) recently said increasing the number of Americans with health insurance is a top priority for the new Congress and the President.

A Shrinking Market Shows Signs of Promise

The individual health insurance market served an estimated 8.6 million Americans in 2001, down 11.5 percent from 1997, according to Mark Pauly of the University of Pennsylvania, who presented an overview paper he co-authored with HSC Vice President Len Nichols. Administrative costs are higher in the individual market than in the group market, primarily because it costs insurers more to sell policies to individuals. The nongroup market also suffers from adverse selection, since those who seek coverage on their own are more likely to have health problems.

"The nongroup market works passably well, even for high risks... . Perhaps 80 percent of nongroup households have access to acceptable premiums."
– Mark Pauly, University of Pennsylvania

"The individual market cannot guarantee everyone access. You are virtually 100 percent likely to be turned down if you have HIV, arthritis, brain injury, cancer, diabetes, epilepsy, heart disease... ."
– Karen Pollitz, Georgetown University

"Whether you think the individual market is a good place to buy or not, many people have to buy there, and they do need assistance."
– Janet Stokes Trautwein, National Association of Health Underwriters

"The word, 'crummy,' comes to mind when I think about the individual market."
– Steven B. Larsen, Maryland Insurance Commissioner

"On the face of it, high-risk pools should work just fine... . However, they don't, and their failures are stunning."
– Deborah Chollet, Mathematica Policy Research

Despite its shortcomings, Pauly and Nichols concluded "that the individual market works acceptably well for about 80 percent of potential buyers." These are primarily people in good health with incomes high enough to afford coverage, but some with health problems also find coverage at acceptable prices. However, Pauly and Nichols also found the individual market is unlikely to work well for the roughly 20 percent of those eligible who are in poor health, especially those with low incomes. Efforts to force insurers to take all comers or to limit premiums "have uniformly reduced coverage in states that have tried it," Pauly told the conference. State-run high-risk pools can help stabilize the rest of the individual market, he added.

HSC researcher Jack Hadley estimated that 7 percent of people with individual insurance are in fair or poor health, compared with 21 percent of the uninsured. His conclusion: either those who buy individual coverage are healthier, or the market screens the sicker ones out. Tax credits indeed would provide substantial help for many healthy and younger uninsured Americans but would need to be adjusted for age or health status if they were to help the "sicker, older, poorer uninsured," Hadley said.

Tax Credits Could Help "Millions"

Providing tax credits to people who are uninsured "would enable millions of people to purchase health insurance," said Katherine Baicker, an assistant economics professor at Dartmouth University and former economist for the White House Council of Economic Advisers. President Bush's proposal to provide credits of up to $1,000 for individuals and $3,000 for families would help six million uninsured Americans get insurance, Baicker added.

Baicker noted that 80 percent of uninsured families have someone in the workforce, and 60 percent have incomes above the poverty line. Any policy to reduce the number of uninsured must be flexible, she added. "No single approach is going to... capture them all." She stressed the importance of coupling tax credits with expanded subsidies to high-risk pools. The Trade Adjustment Assistance Reform Act moves in this direction, providing tax credits to workers who lose jobs due to trade, along with $80 million in new funding for state high-risk pools.

"Not Ready for Prime Time"

Karen Pollitz of Georgetown University's Institute for Health Care Research and Policy argued against increased reliance on the individual market. "The current market makes coverage less accessible, less affordable and inadequate to meet the needs of many people without insurance, especially those who have modest incomes or are in less-than-perfect health," she said. Her presentation, based on a paper co-authored by HSC Senior Researcher and Public Affairs Director Richard Sorian, drew on earlier research done on the individual market.[2] Pollitz and Sorian presented insurers with applications from seven fictitious people with health problems, ranging from hay fever to depression to HIV infection. The applications were rejected 37 percent of the time, and many of the other policies came with riders that restricted benefits and/or charged higher premiums.

One approach to resolving these concerns is "better risk spreading," said Maryland Insurance Commissioner Steven B. Larsen. "Health insurance is a quasi-public or public function [that is] delivered by the private marketplace. If we acknowledge that it's a public function, then maybe we're more comfortable with a much greater level of regulation than we have today."

Mark Hall, professor of law and public health at Wake Forest University, questioned the notion that proffering tax credits could solve the individual market's problems. Policy makers cannot just wave "a magic wand" and make the individual market operate like the group market, Hall said. He suggested expansion of group coverage

might be more practical with alternative subsidy vehicles.

Insurers View Market Favorably

Janet Stokes Trautwein of the National Association of Health Underwriters said policy makers should focus on the millions of people who are well-served by the individual market. "Contrary to some assertions, coverage for [the chronically ill] is widely available, and benefits will not always be greatly restricted." Some policies are a good buy, even with riders or exclusions, she said.

Tom Miller, director of health policy studies for the Cato Institute, dismissed adverse selection as "a trumped-up bogeyman." The individual market is small because the tax system is so tilted in favor of employer-sponsored group insurance, he said. Regulatory mechanisms that block insurers' ability to select their customers have failed. "They don't make individual insurance more available to high-risk consumers because they drive the low-risk people out of a thinning voluntary individual market, and they raise overall premiums," Miller said.

Leaders of two major insurers expressed bullish views about the individual market. Thomas B. Hefty, CEO of Cobalt Corp., and its Blue Cross and Blue Shield United of Wisconsin, and John Bertko, chief actuary for Humana, Inc., said sales of individual policies are growing rapidly in their markets.

Hefty said the uninsured rate in Wisconsin, which does not limit premiums, is half the national average. Wisconsin is among 10 Midwestern states where more residents are enrolled in private plans than in Medicaid or other government programs, he noted. Purchasers include "young people...baby boomers and early retirees in particular who have fallen out of the [group] market." He suggested that bad public policy, not a bad market, was responsible for other states' high rate of uninsured. If families know they can get public coverage if they get sick, they won't buy private coverage while they're healthy, he said.

Humana, a newcomer to the individual market, sees "big opportunities," Bertko said. Half its applicants for individual coverage "go through clean and get a policy issued," he said, but 10 percent to 20 percent may be uninsurable. Adverse selection is a big problem. "People seek insurance because they need it," Bertko explained.

High-Risk Pools Offer Some Help

Thirty states have established high-risk pools for the medically uninsurable. Minnesota stands out with 6 percent of covered lives in its high-risk pool; Oregon and Nebraska each have 2 percent. The other pools cover less than 1 percent.

"Risk pools, as they exist today, serve a small but important niche," said Bruce Abbe of Communicating for Agriculture. "They provide a guarantee that everyone in the insurance market has a place to buy insurance if they're willing to." Risk pools aren't perfect, Abbe added, but they provide a significant subsidy limited by funding constraints.

Deborah Chollet, a senior fellow at Mathematica Policy Research, Inc., noted that most high-risk pools have experienced problems that mirror those of individual markets. The coverage is expensive, waiting periods long and benefits limited, she said. Some of their failures "are stunning," according to Chollet. Florida shut down its pool because of inadequate funding, and California, Illinois and Louisiana have capped enrollment and periodically barred new entrants.

All high-risk pools have waiting periods before covering preexisting conditions, and they charge 25 percent to 100 percent above standard premiums. Most strictly limit mental health benefits, and 10 do not cover maternity. "There's a lot of leakage in this 'fix,'" said Chollet. She also noted that insurers prefer high-risk pools to more state regulation. Those who see the glass as half-full argue that high-risk pools provide better protection than nothing, and Abbe noted most people use them as transition bridges either to Medicare or back to group coverage.

"There will always be an individual market... .We should not ignore it if we want to reduce the [number of] uninsured."
– Bruce Abbe, Communicating for Agriculture

"Is the individual market better than nothing? Certainly. Is it better or equivalent to the group market? That's where the real problems lie."
– Mark Hall, Wake Forest University

"If the government were the reinsurer, we would end up solving the adverse selection problem... .We'd spend much less money trying to screen out very high-cost people."
– Katherine Swartz, Harvard University

"If we all agree some people could be served by this market, but others cannot...it shouldn't be too much rocket science for analysts...to devise policy options that real people [legislators] could pass."
– Len Nichols, HSC

Government as Reinsurer

An idea that sparked wide interest at the conference came from Katherine Swartz, professor of economics and health policy at the Harvard School of Public Health. She proposed having the federal government assume the role of reinsurer for buyers of individual coverage with the steepest medical bills. Swartz said the government should step in for those with the most expensive 2 percent or 3 percent of health care costs. Carriers would still bear responsibility for most medical expenses, but not the catastrophic costs that attend a serious accident or life-threatening illness. Much of the underwriting insurers do to avoid the worst risks is futile, Swartz said, because "it is really impossible to predict who will be a very, very high-cost person." People in the top 5 percent one year seldom are in the top 5 percent the next, she said.

"If the government were the reinsurer, we would end up solving this problem," Swartz said. The government already plays the role of reinsurer for natural disasters, having bailed out the airline industry after the September 11 attacks, and it assumes responsibility for the worst-risk mortgages, she noted.

Views from Capitol Hill

Senior congressional staff also weighed in. David Nexon, health staff director for the Senate Health, Education, Labor and Pensions Committee, offered the most pungent commentary. "There's an old saying that you can put lipstick on a pig—but it's still a pig," Nexon said. With steep administrative costs, the individual market is no way to help the uninsured, Nexon added.

But Patrick Morrissey, deputy chief of staff on the House Energy and Commerce Committee, said he viewed the task at hand as refining a market to make it work better. Consumers want to make their own health care choices, Morrissey said, and tax credits will provide that flexibility. Any solution will require "a viable high-risk pool system."

Elizabeth Fowler, chief health and entitlements counsel for the Senate Finance Committee, said Democrats might resist expanding tax credits until they see how the tax credits provided for in the trade act work out. "I do think it would be difficult to reach agreement on uninsured policies in the coming Congress without going down the road of an individual tax credit in some form," Fowler said, along with an expansion of public programs.

Finally, Dean Rosen, Republican staff director on the Senate HELP Public Health Subcommittee, recalled that in E.B. White's classic, *Charlotte's Web*, the enterprising spider of the title helps people to view the pig in a more positive light. The current individual market is small and fragile, Rosen said, but people shouldn't look at it as it is now, "but [as] how it can be."

Finding Common Ground

Despite the strong opinions and diversity of views expressed at the conference, Nichols found evidence of some meeting of minds. Participants agreed that the individual market "does work for some people—but probably can never work for other people," he said. The biggest disagreement is what to do about those who are left out. Nichols concluded that the policy debate boils down to a single question: "Do you want to cover the relatively many low-risk people who could take the tax credits and buy reasonable coverage in the nongroup market without much regulation, or do you want to focus your limited public dollars on the smaller but more vulnerable high-risk population?" The answer to this question will go a long way toward determining whether policy makers prefer individual tax credits, expansion of public programs or more subsidies for the private group market as the next step toward reducing the number of uninsured.●

Notes

1. See "The Nongroup Market: A Web Symposium," *Health Affairs* (October 2002), available online at www.healthaffairs.org/WebExclusives/Nongrp_TOC.htm.
2. Pollitz, Karen, Richard Sorian and Kathy Thomas, *How Accessible Is Individual Health Insurance for People in Less-than-Perfect Health?* Report for The Henry J. Kaiser Family Foundation (June 2001), available online at www.kff.org/content/ 2001/20010620a/.

This Issue Brief is based on a conference sponsored by HSC and *Health Affairs*, titled "Individual Health Insurance: Fact, Opinion and Policy," held October 23 in Washington, D.C. Moderators were HSC President Paul B. Ginsburg and *Health Affairs* Founding Editor John Iglehart. For a full list of presenters, transcript and webcast of the conference, go to *www.hschange.org.* ONLINE

ISSUE BRIEFS are published by the Center for Studying Health System Change.

President: Paul B. Ginsburg
Director of Public Affairs: Richard Sorian
Editor: The Stein Group

For additional copies or to be added to the mailing list, contact HSC at:
600 Maryland Avenue, SW
Suite 550
Washington, DC 20024-2512
Tel: (202) 554-7549
(for publication information)
Tel: (202) 484-5261
(for general HSC information)
Fax: (202) 484-9258
www.hschange.org

Select Committee on Affordable Health Care for Floridians

Public Hearing

(ADDENDUM)

November 4, 2003
3:00 PM – 7:00 PM
Tampa, FL

Johnnie Byrd
Speaker

Frank Farkas
Chair

Committee Members in Attendance

Representative Kim Berfield
Representative Donald Brown
Representative Donna Clarke
Representative Frank Farkas
Representative Gayle Harrell
Representative Ed Homan
Representative Marcelo Llorente
Representative Sandra Murman
Representative Dave Murzin
Representative Pat Patterson
Representative Eleanor Sobel
Representative Baxter Troutman

Committee Members Not in Attendance

Representative Rene Garcia (Excused)
Representative J. Dudley Goodlette (Excused)
Representative Carole Green (Excused)
Representative Bev Kilmer (Excused)
Representative Yolly Roberson (Excused)

Regional/Local Delegation Members in Attendance

None

Johnnie Byrd
Speaker

Frank Farkas
Chair

Public Testimony by Individuals not on the Agenda

Name	City/State	Representing
Alan P. Saylor	Pinellas Park, FL	Self
J.J. Hartley	Riverview, FL	NFIB / FL Dry Cleaning Coal.
Dave Rogoff	Tampa, FL	Hillsborough Co. Health & Social Services
David Siegel, M.D.	Tampa, FL	FL College of Emergency Physicians
John Sinibaldi	Seminole, FL	Self
Timothy Pitcher	Nokomis, FL	FL Health Underwriters, FL Assoc. of Ins. & Fin Advisors
Jon Preiksat	Venice, FL	Venice Area Chamber of Commerce
Victor A. Craig	Arcadia, FL	Craig's RV Park
Gary Carnes	St. Petersbury, FL	All Children's Hospital
Wayne Sakamoto	Naples, FL	FL Assoc. of Health Underwriters
Elizabeth Rugg	St. Petersburg, FL	Suncoast Health Council
Dr. Michael J. Ropele	University Park, FL	Self
Martin Williams	Tampa, FL	Self
Paul R. Olszewski	St. Petersburg, FL	Nurse Alliance
Rand Pierce	St. Petersburg, FL	Persons w/Disabilities
Bob Wirengard	Fair Share, FL	Self
Ron Stephens	Estero, FL	FSMIA/FL State Massage Therapy
Ulysses Coster	Apopka, FL	Farmworkers Assoc. of FL
Geraldean Matthew	Apopka, FL	Farmworkers Assoc. of FL
Florence Brown	Ft. Myers, FL	Self
Ernesto Pichardo	Hialeah, FL	Conseqo de latines Unidos
Patricia Gallant	Estero, FL	Jack Brown – my uninsured brother who needs surgery
Becky Martin	Bradenton, FL	League of Women Voters, Manatee Co., FL

Most people see what is, and never see what can be.—Albert Einstein

citizen robert wirengard
6234 N. Falkenburg Rd./Hillsborough County/FL 33610; Tel. contact, 813-758-7595; fax, 813-612-9709; e-mail, rowireng@tampabay.rr.com

October 8, 2003

To: Candace Hundley, Director
The Office of the Hillsborough County Legislative Delegation
Copy: State Senator Tom Lee and Representative Dr. Ed Homan (co-sponsors are required)

Due for Submission by Noon, November 21, 2003
Legislative Proposal for Hillsborough, County, Florida, Open Market Care

Greetings,

What we have here is Open Market, Fair Share Care that is deliverable within a year. When it is free, with a "hands off" government that stands for goodness and enforces the fundamental laws of fairness, equal treatment and goodness, itself, and expects these of the private sector, be not afraid. Fear instead our government's "hands on" position that, worse, is sharing our taxes with "hands on" corporations, something that Abraham Lincoln warned about, what corporations, someday, might do to America. It is time to free persons, now, allow persons to manage themselves, and for government to transform its legislative focus to the personal responsibilities that come with freedom: no more abuse. It is time for persons who live by, hold and advocate freedom, equality and treating others as we want ourselves to be treated, to stand up and command Open Market Care from our legislators. It may seem a frightening proposal; but, time and again, throughout what is written herein, they are the frightening details that must be addressed clearly, with no room for ambiguity, or we will remain where we are, leading the world in war, not peace.

Also within this writing are believed to be all the criteria and data that is required by law for legislative proposals; or please advise immediately of anything that might not be met. Note that the fifth item, starting on page 6, sets forth the "nuts and bolts" of the proposal which should be reviewed by county staff programming and systems hardware people; and that a federal proposal has been made into an addendum hereto.

I have worked extensively in areas of Dr. Milton Friedman's "negative tax" theory to end processes of impoverishment. I call them processes, because we know that many if not all of our poor would live well, on their own, if we were able to allocate to each "forty acres [of rich land] and a mule". Once impoverished, as of land, however, a person may survive on a hand to mouth basis, doing for or to others whatever might be necessary to do so. "Doing for" is a depressive subsistence that does not allow one to thrive or celebrate life, and it often is seen in blank, confused or staring-into-nothingness eyes. Those "doing to" us, who might know

that they have been wronged, may be bitter, express anger and sometimes retaliate in socially "unacceptable" ways, being perceived as arrogant or, at times, as the terrorists.

Putting righteousness aside, those who are in poverty struggle against three things: hunger, exposure and illness. We may not see dead lying on our streets, but we see that a hungry or malnourished child - or grownup - cannot concentrate; that hot, humid heat, instead of air conditioning, adversely affects learning processes and mental performance skills; and that combinations of the foregoing lead both to accidents, illness and, in fact, early deaths that might be defined under heat stroke, other exposures or malnutrition, including from being overweight due to poor diets that "fill up" but not properly (fatty food is less expensive).

While our general population has nearly doubled its life expectancy to 78 years, as compared to a mere century ago, the processes against Afro-Americans have left them with a life expectancy of 13 years less; Native Americans, 20. The latter's deaths come earlier; and it is in a social twist that Euro-Americans might call them "takers" while we forcibly took their lands from them or them from their lands; and despite that more "white" people are on welfare rolls.

Furthermore, the vast majority of these are women; this, while social programs that favor men are called entitlements. [Women who married, up until 1798, gave up all property rights and would be impoverished upon the death of their husbands, if the husbands cut them out of their wills. Also, before World War II, many Euro-nations would not allow Jews to own land, forcing them into careers of trade and, in a twisted way, to be perceived as greedy, money dealing people since, the whole time, we were the none-Jews who were greedy about keeping our land.]

And psychological studies show that those who are failing will be inclined to take higher risks. This is seen not only in Mr. Delorean having tried to sell drugs to finance his failing automobile plant, but also among poor persons who easily are exploited to sell them, even young ones, since the low wage will seem big to them, plus, saving their elders, the younger ones suffer lesser punishments, when caught. It is proven in that relatively more poor people buy a moment's dream or hope through lottery tickets; and it is seen in women turning to prostitution for higher income (if they had any in the first place). The latter may be a $10 deal on the street or it may be a thousand dollar one, in a grand suite, with lesser chances of being caught or catching a socially transmitted disease. And many homeless women are not counted, because men will use them and let them spend nights in their homes. [I remember one, Angelica, her eyes, when she could have purchased a mobile home for $1 by agreeing to a monthly lot rent of $270, and her disappointment, as someone else got it.]

Something is terribly wrong when a man bilking many of their life-time earnings - what it takes many to work for and produce throughout their entire working careers, their life's work becoming destroyed - wind up in a gentleman's prison, become paroled or pardoned AND to go back to the kind of work he did before. Things are not so for blue collar criminals, where, destroying one life may result in death or life-time imprisonment (local, stark humor being that "In Florida we send drunks to jail; in other states, they send them to the White House; this is

not funny, it is a reflection of poor versus wealthy).

With more than 2 million people in jail or prisons, our United States of America leads the world in having the highest of incarceration rates, and our county jails are over-flowing. Prisoners come primarily from our poor ranks, the wealthier people not being caught or, if so, not winding up in court or prisons. Yet, the facts remain that even with the highest prison rates, our crime rates have not declined but also lead to be among the highest in the world, starting with murders, including wives, and with much abuse...and our county's is among the highest crime rates in our Nation. (Crime itself goes up or down with our economy; and so long as we have not solved poverty, as many nations to a large degree have, our crime rates will remain higher than theirs; and many women, too, stay in abusive relationships, including those where the man is wealthy - abusers have social boundaries but not economic ones.)

I have focused on the health care issue, where 44 million Americans do not have coverage and a half million are impoverished annually - file personal bankruptcies with medical bills - after millions of others have settled with partial "write-offs" by professionals, were turned over to collection agencies or were paid for in part or "full" by insurance or government agencies that had preferred pricing, as low as one tenth of the price to the private citizen (a self payer may be forced to pay $25,000 for an appendectomy or $9,000 for glaucoma surgery; an HMO, $5,000 or $900, respectively. As with welfare, women are the primary recipients of Medicaid. Our health care system is a socio-economic mess).

You, representing the State of Florida, not only passed a law mandating our county to take care of financing of indigents needing health care, without any assistance from you (the taxes we pay to you or our federal government); but you also passed later legislation that we were not paying enough to Tampa General Hospital, a private hospital that rents its facility from our county for $10 a year (while we are charged more for parking there). You mandated us to pay them an additional $3.5 million per year, without clarity in how many indigents they actually had treated, and without any reduction or elimination of this annual payment when the hospital prospered and became profitable. Such activity and behavior on your part creates an even greater socio-economic mess for our county.

And, while taking a hard look at our programs and comparing those with many of the world around us, we have had to come to two conclusions about existing programs. The first is that "cheap is more expensive"; not only in terms that "a stitch in time saves nine", including seeing a doctor for ongoing treatment rather than later having to pay for emergency rooms; but also that budget restraints are directly linked to and cause backups in needed care, secondary treatment and even deaths (we may face yet another law-suit, in this respect, unless it is contained at a malpractice level; similar to HMO's not being liable - may not be sued - for their low-ball budgeting or the price pressures being behind malpractice events).

The second conclusion is based on knowledge that a third party cannot legislate or dictate prices in the private market place without creating adverse effects (making a mess of things, throwing the market out of balance). And that "setting of prices" is universal among both socialized medicine, such as our Medicare, Medicaid and county health care program and in

the "privatization" of such programs, as through HMO's that muscle even harder prices than socialized programs from health care providers (I say "muscle" them, because as buyers they are engaging in monopsonistic behavior; which mirror monopolistic sellers who are enabled through monopolistic power to do the opposite, command high prices). [Health care providers now are trying to retaliate, as in nurses or doctors forming unions, a form of monopoly to fight the monopsonists driving their relatively low incomes; or hospitals in a Texas town joining into one - a monopoly - to tell the HMO monopsonists that their low, muscled prices no longer are acceptable to them (like, "Let's see if you can get care for all of your patient-members from the few remaining hospitals that we do not own.") Fighting fire with fire is destructive, any way you look at it; and regulating prices or other third party pressures to reduce them, hurt both the professionals and the patients - us, we, the people.

Dr. Friedman has outlined both the key problem of health care (that others are spending your money for you) and the key solution (health care savings accounts, from which to spend one's own money). By establishing a one-payer savings account that is financed by employers (they are people's principal source of income), people then are empowered to pay their own bills by getting a budget for each type of health care incident that is calculated and based on average prices or "going rates" that are kept up to date as bills are submitted by licensed physicians, hospitals and drug stores (etc.). [NOTE, we are allowing doctors to charge whatever prices the might! - but only budget and pay out the average amount]. Having the budget, patients will spend funds in a way that is identical to spending their own funds and never will be denied going rate care, or forced to take second rate care: if they use a more expensive doctor, then they "co-pay" the extra; a going rate doctor, the latter is satisfied/paid in full; and a lower priced one, the patient gets the difference (gets the profit or budget savings, rather than an HMO or our government).

The latter element is critical, because, in the process of publishing actual going rate prices, this introduces competitive prices among providers (a patient will know whether they are charging more or less than other, and up front) and, thereby, this will keep a check on spiraling costs, as well as on the recent decades of polarization between relatively low income, primary physicians (pressured by Medicare, government programs and HMO's), and the materially more expensive or pricey specialists (like surgeons). That is, in the new arrangement, primary physicians may charge higher prices that are more reasonable for their needs (and attract more of them into that end of the profession), and specialists may come down in prices (private specialists may be worthy of 50% or twice the price of a current government or HMO surgeon, but not10 times more). Seeing the differences in prices among the same level of professionals, patients not only will be surprised but shocked; and the Open Market Health Care model is the vehicle for straightening out our current mess.

In fact, a recent small experiment that identically budgeted disabled persons to spend funds, the patients not only proved more satisfied but also "happier". And, more important, from a financial aspect, a recent Harvard study showed that $294 billion is wasted in America between patients getting approved for treatment and doctors getting approved for payments. This means that 20% of our health care costs are wasted or benefit only the third party gatekeepers; and, with a one-payer system, that allows patients not only to manage their

care but also to share in savings from detecting erroneous billings, plus that simple, systematic, post audits quickly can detect fraud, the 20% waste and legitimate administrative costs can be reduced to be less than 1% of current health care costs (such are the administrative costs of collecting and paying funds in private businesses). Being able to charge what they want, doctors will not be under those economic pressures or to prescribe "preferred" ("cheap" or "kick-back") providers that result in malpractice and/or today's sky-high, U.S. prices. The Open Model has greater potential than Canada's (where drugs now are considerably cheaper), because the market sets its own prices while Canadian province ministries negotiate and set rates for the different health care procedures.

To institute the program for our Hillsborough County or our state of Florida, requires legislation. For our County, it requires for the state legislature to authorize us to proceed, because we are not allowed to tax ourselves without your approval! Will the state legislature please do so, so that we may commence to work with our community and its constituents, to get their buy-in, understanding and acceptance? By any and all of you being silent on this, now, and not rejecting our request, this means to us that you all will be co-sponsors of this, our legislative request to you.

Other than this, the state of Florida would follow identical legislative needs that would be instituted at our County's level.

First, doctors and hospitals and all providers will have to be called upon to honor the letter and/or spirit of the Robinson Patman Act, which states that sellers should not discriminate (have preferences among customers) in prices, except to meet a competitor's prices or for a few reasonable instances such as for volume (that saves set up costs and on "shipping and handling") or classes of trade (wholesalers over retailers, for the same reasons) or Original Equipment Manufacturers that use the product within their own product (and which the customer may choose for replacement, should that product need replacement). At no point, however, is a seller allowed to sell at below costs in order to "kill" or outlast the competitor! Doctors, hospitals and providers need to be educated, to understand, accept and COMPLY with this federal legislation. Law suits may commence if they do not.

Second, our county, state and federal agencies and the private insurers that also force doctors and hospitals into accepting discriminatory prices should cease such behavior and activities immediately, amend and commence to pay the list prices of doctors and hospitals, with the only reasonable differences from these complying with the reasons defined by the Robinson Patman Act. This means that our county no longer may negotiate prices that are lower than Medicaid's, and that Medicare may not set a price ceiling on any doctor or provider.

Third, our county will need to continue the aberration of our 1%, general sales tax that is earmarked for our county's current health care program. However, rather than it being for our "indigents" or poor, it will have to be earmarked for those employer/employees that compete state-wide and globally, primarily our agricultural industry, so that we may exempt them from our employer tax, in order that they remain globally competitive.

debit cards which will have their identification code (federal tax identification or social security number, as the case may be) and license codes, wherever these apply. Conceptually, we wind up with three primary master files: employers, employees or patients, including indigents, partners and children, and licensed physicians or those licensed to prescribe care, such as medical prescriptions. Note that nothing may be done in medical health care without "doctor's orders"; although the system also should allow for those people who designate surrogates - in cases of mental incapacity - for those surrogates to be identified to doctors, as well as when Living Wills have been documented or organ donor ship. Furthermore, note that doctors might be allowed to enter their patient specific files, other than bills, such as their diagnosis and recommended treatment; and that the best system also should be able to accept such things as lab test results on blood, urine or other tests, X-rays, other imaging products or sonograms; all of which may be accessible to other physicians authorized by the patient. A patient should have access to such documentation or materials, with the possible exception of a psychiatrist's entries (for other psychiatrists to see, whom the patient might have?). And, finally, patients also should be able to post their comments, about a doctor or provider, but might not anonymously do so. Throughout this, we have three primary master files with code specific identifications: employers, people and doctors, each of which may have respective input and file maintenance requirements (changes of names, identification or addresses); and doctors may "audit" patients (has the patient had too many pain medications that may indicate an addiction?); while the most universal power rests with the private person/resident/participant: they may audit employers and/or physicians/providers for financial errors and will participate in the savings from uncovering such errors and from the fines that may be levied for such errors (the fines should not be punitive for "honest mistakes", but may cover administrative costs for unveiling and correcting them, including something minimal or reasonable for the patient's time involved. Furthermore, the system should be designed with specific audit tests that reveal, for example, patterns of "errors", significant variances (many prescriptions) or even indicate fraud or collusion on the part of a patient and doctor/provider. In the latter cases, they are the professionals - doctors and/or providers - who should suffer the greater punishment, such as becoming de-licensed, and as swiftly as possible. Our court system also may register pending malpractice suits and the disposition of malpractice suits that found in favor of the plaintiff - we expect suits to decline however, because doctors will not be under pressure, other than competitively, to minimize care, as results from minimized budgets or price dictation or otherwise gouging, price wise. Aside from courts providing data, consumer groups or books publishing those physicians with adverse records may be on-line for our public's easy access. And finally, finally, for now, the system should inquire of physicians whether they receive any kind of benefits, rebates or kickbacks from what they may prescribe, or rely solely on their billings to the system for their medical associated income. This is important, because we may need to distinguish in price averages between the two types of physicians, the former being able to out-compete the latter in their pricing schedules, giving the latter a competitive disadvantage that should not be acceptable to the one-payer system. That is, it should keep separate price averages and pay out or budget separately, per these averages, respectively for the two types of physicians (or hospitals or providers that also may have conflicts of interest in medical matters).]

Fourth, we also may exempt all those employers and their employees that already provide and have health insurance coverage; AND, if there is any law that suggests that we may not tax employers who do not provide health care coverage, to provide it through our program, then such laws must be struck. This, along with our current state regulation that prohibits against federal regulations the establishment of a Multi Employer Welfare Arrangement (MEWA), under ERISA, through our state's discrimination that a MEWA only may serve one industry (as though employees in different industries may not have the same illnesses!).

Fifth, our county may enter into an agreement with a private sector MEWA or SGE (Semi Government Entity, like our federal government's Federal Reserve Bank system). This means and gives distinct clarity to an arm's length that our government no longer is involved with private sector health care decisions (these should be between doctors and patients), nor setting prices (what is to be paid should be independently calculated by the private, one-payer system; price averages changing continuously as bills are received), and for private medical not to be accessible by government or its agents (privacy is a constitutional law made clear in the Constitution of the United States of America.) Nor should the GSE or MEWA make public individual records to government or anyone (at least not without the individual person's express consent; nor should physicians have access, without consent - by the way, they may decline care for a patient who does not provide such consent, and this should be confirmed by legal counsel). The MEWA/GSE may and should make public as quickly as possible, for example, to a health alert agency, any spreading or contagious illness that is detected; or, for example, where a family history holds in common with similar histories a reaction to a specific medication that might be in test stages or in full use in the market.

The one-payer system, however, will work with governments - local, state and federal - and their respective agencies, including our Internal Revenue Service, to disclose gross payments contributed by employers, and payments made to doctors and providers. The system should empower those employers who want to load data up electronically to do so. Such data will include their federal identification code, the amount contributed from their payroll, the identification or social security numbers of the employees covered by each payroll (and their dependents), and the separate amounts that are paid per each employee's wages, within the total payment (this will allow employees to audit that their employer is making contributions and, also, will give them a running tally of how their work has contributed relative to the amounts that eventually may be spent by each - it's a good thing, just to know). The system, incidentally, should be able to track for people and separate sums from different employers they may work for, chronologically or at the same time, and, as well, when dependent partners or children start to work, reporting to them their individual accounts. [By the way, each employee and their dependents should be issued an Open Market Care card, similar to common credit cards, that also should have an identification number that may capture their nation, state and city/place of birth (by six alpha digits, or postal zip codes), their birth date in alpha code and social security number; also, with reports of new-born babies, their Social Security number needs to be arranged for immediately, as well as for their health care coverage; and death notices should be arranged for the system to receive as well. Licensed doctors and providers also may be issued Open Market Care

Beyond the three primary master files, secondary master files should be part of the one-payer system. To make knowledge more readily available and accessible to the public, for example, a grid may be established not only for pharmaceutical firms to list their drugs, their specific properties or values and suggested retail prices; but also for a consumer group (or person with a bad drug reaction), such as Public Citizen's "Worst Pills Best Pills" publications of many, if not all drugs, their effects, their affectations, and, quite important, effects or affectations due to taking a variety of combinations of drugs. These well may juxtapose what the manufacturer enters into the grid about their drugs. Plus, in such a complex market, with an extensive number of drugs, this secondary file can be of key importance to physicians (they may be called upon by six different sales representatives from the same pharmaceutical firm!), especially when they discuss with patients which drug they should prescribe.

In the same vein, it is critical for the one-payer system to distinguish among Diagnostically Related Groups (DRG's), as well as diagnostically related (families of) drugs. For this, an independent board of physicians needs to be established to meet as regards how the one-payer system should calculate average prices. For examples, an identical form of cancer might be treated surgically, by chemo-therapy or radiation, and a given pain, by a number of different drugs. The board should decide whether the different treatments and different prescriptions should all, respectively, be averaged together for one average price to prevail, or should the prices be averaged within the specific treatment and/or drug.

Plus, the one-payer system should have Medicare and Medicaid codes and their respective price lists downloaded for public reference, public comparisons of prices and so that the thousands of codes and medically worded texts - upon which all their medical bills are based, and which serves as an index for the entire medical industry - can be translated into "user friendly" terms and common language. For example, a common citizen seeking to find out the going rate or market price for a heart specialist or an appendicitis treatment, should not have to know the medical terms and/or codes for these, but should be able to "drill down" within a few layers or "search" to find the respective medical terminology, their codes and average prices (and Medicare's and Medicaid's).

[Note, it is in the previous two items - the DRG's and Medicare's codification and prices - that Bob Wirengard has found the greatest difficulties, in ascending order, for the one-payer system's design to be realized. If any experts see or anticipates other types of application problems, then please let him/us, know. Note also that an independent firm provided an estimate of $360,000 for the programming and hardware to be put in place for the one-payer system, and that this would accommodate our community of 1 million people, its doctors, hospitals, drug stores, and providers. The hardware estimate was less than $200,000, meaning that the program could be established - be put in place - for less than $50 million to accommodate our Nation's 280 million population. And note that it will give rise for programming firms to come up with systems compatible programs - as for "PC's" - for doctors (and hospitals, etc) to use, as it well may be in their interests not only to set up/publish their price schedules but also see going rates and to inter-relate with or more easily get payments from the one-payer system. Ditto, for employers, especially those that already do not have programming staffs or pay-roll servicing firms of their own.]

As to our private sector's involvement, reference **Pages 3-4, Private Sector's Infrastructure Made "Concrete" for the Open Market Care Proposal, of the national Open Market Care proposal.**

Sixth, our county should receive back, from any and all of its federal and states taxes, our pro rata share paid into such federal or state revenues, as regards health care; and should not have to pay any matching grants, etc., in order to get them. If and when state and federal authorities decide to end their discriminative distributions of such funds OR adopt our program, then this sixth item becomes moot. We would not need a 10% local tax on local employers, because our higher levels of government already are collecting for health care coverage, and we would not need to double tax ourselves for it, just to prove that the Open Market Care system works! County staffs [David Rogoff's] immediately should coordinate and calculate on a pro rata basis how much in funds should inure to our county for our own management, including but not limited to state taxes and federal income taxes and Social Security allocations made to health care, Medicare, Medicaid, Kid Care and Veterans.

Seventh, provided all of the above, including the pro rata Medicare and Social Security taxes used for health care (as in paying HMO's added supplements) or that we exclude our elders from our county program, then we should be authorized to tax our employers up to 10% of their pay rolls, which is what our local government currently pays for its employees' health care program (including our school board, which does not provide coverage for substitute teachers, subcontractors and more).

Eighth, while herein we are focused on universal health care, should our federal legislators not consider the living wage arrangement set forth in the national Open Market Care proposal, all welfare funds pertaining to food and shelter also should be pro rated for our county (or state). It is with sadness that our county has seen the vestige of a Seminole village, by our county's fairgrounds, and its culture, evaporate, even its museum closed down; pushed out and replaced by an establishment of gambling, alcohol, cigarette sales, a rising Hard Rock Café and not one woman listed as among the Chiefs on their website. We socio-economically have cultivated the vices of white, Euro-Americans; and Washington has a team called Redskins. You socially may put down being "politically correct", but you are wrong to do so.

And I have a natural law that pertains to Justice: anyone who resorts to violence is not using their brains.

If we do not start, even with the first item, as regards pricing and the Robinson Patman act, then authorities should be brought in to determine, for example, possible breach thereof by the county paying a materially lower price for an X-ray, a product, than its system -Tampa General Hospital being the private pay billing system - charges an insured or private pay patient. We are facing other potential law suits already and in other areas, linked to budget deficiencies and laws that are in conflict.

It also now is clear that our 1% general sales tax is insufficient to meet the growing needs of our county's health care program. It also now is clear that a need exists in our community for

low income earners and small businesses that cannot afford conventional insurance - but that can pay something - to partner with and expand from the base of participants and revenues of our county health care program. In fact, a number of large employers who, for a variety or reasons, do not provide some of their employees or workers with health care coverage also should participate, and be forced by law to do so, in order that competing firms be kept on "level playing fields" as regards their completion for employees.

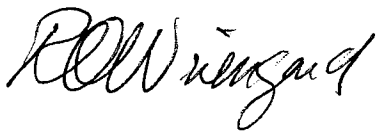
I, also, herewith submit three documents, the first of which is titled "The State of Florida's Constitution prohibits income taxation, and this is one point where Florida is correct and our Federal Government is wrong". It discusses taxation, benefits and implications related to the foregoing paragraph. In fact, tax savings, by funds staying here rather than going to our federal government should be calculated by county (and state) administration and be compared to the pro rata calculations of the sixth item.

The second document, "Hillsborough Care, a Government Sponsored Entity. What it Means", was presented to our Hillsborough County Commissioners on December 4, 2002. It is to explain the structure of a partnership program, tax implications and benefits for our County also.

And, thirdly, "Proposed Legislation for the local, Hillsborough County Indigent Care Program", as it relates to the above or an expanded "Hillsborough Care" program, and what we need our state representatives and Delegation to work with us on.

I understand that individual co-sponsors in our House and Senate are needed, and it is therefore that I am copying Senator Lee, my state representative. A "point-man" is necessary to work with us and our Delegation on this, and I hereby ask if you, Senator Lee or Dr. Homan, will do so? My personal commitment is to work with an attitude of "whatever needs to be done" to get correct legislation for our care program, and as soon as possible, because people, especially low and no income ones, are hurting.

Sincerely,



citizen robert wirengard
6234 N. Falkenburg Rd./Hillsborough County/FL 33610; Tel. contact, 813-758-7595; fax, 813-612-9709; e-mail, rowireng@tampabay.rr.com; and (educational, experimental website)
an equal opportunity employer

The State of Florida's Constitution prohibits income taxation, and this is one point where Florida is correct and our Federal Government is wrong.

People's personal income should not be taxed. People and corporations using employees, for their benefit, should pay an equal rate, usage tax. It should be equal to all employers because they compete for employees and it would be unfair for one firm or employer to have to pay a greater tax rate than another, because they then tend to go bankrupt or have to reduce other costs or benefits.

If our Federal Government, alone, started to implement the correct form of employer taxation, it would get the same amount of taxes it currently gets AND some 160 million personal income tax forms would not have to be considered or filed by people working in America every year, reconciling whether we owed some taxes or whether the government owed us a refund. Such paper work is redundant, costly and argumentative, with people winding up stressed and, in some cases, ready "to go ballistic".

Now, in Hillsborough County, Florida, and with its Indigent Care program, we can start to correct incorrect taxation by all levels of government, from here to Washington. If you will, let us be a "test" case.

(1) We enact a ½ and then a 1% sales tax on employers, which would generate in excess of $100 and then $200 million dollars for Hillsborough's Care program.
(2) Note that those firms in tax brackets of 36% of their income only would be expending .64%, because .36% of the tax otherwise would go to Federal taxes, now will stay here in our Hillsborough County rather than going there. If the weighted average tax bracket of firms is 20%, then $20 to $40 million are staying "home" rather than going to Washington for it to redistribute.
(3) With the 100 million dollars, we (3.1) can double our health care program (3.2) eliminate the half cent general sales tax, let it sunset in 2005, with the employer tax then going to 1% (3.3) reduce real estate taxes, both for plighted areas of our cities and in rural, agricultural regions.
(4) A jointly partnered, one-payer system can be developed and be put in place for $360,000 by NCGI, a programming firm familiar with health care and on the leading edge of federal health care regulations that are coming down-stream or requiring compliance with such matters within the number of years allowed. (Competitive bids should be sought immediately; it took NCGI two weeks to come up with its independently arrived at price).
(5) The Care program needs to be a community one, with an unincorporated, not profitable entity that, in addition to Indigent Care, may arrange for a multiple number of

employers to pay voluntarily into a pool in an arrangement for their employees. (5.1) Individuals or Small Firms, possibly defined as those that are not incorporated, might pay a 4.5% rate into the arrangement. (5.2) Large, possibly defined as those that are incorporated, would pay up to 10%. (5.3) In fact, any large employer, especially our County's and School Board's, should extend the option to its employees to participate in the arrangement. (5.4) Any large employer who provides no health care benefits, such as to part-time workers, substitute's, temporaries and/or contractors and sub-contractors, should pay up to 10% into the arrangement. (5.5) The exceptions to this may be where exemptions to minimum wage laws already exist, and such employers might be subjected only to a 4.5% employee use, sales tax (for example, for waitresses or agricultural workers).

(6) The partnering entity may start to pay prices at indigent care price levels for those people who earn less than $8 an hour, for businesses that cannot afford conventional insurance and for those employees who do not have health care coverage themselves.

(7) For those employees who choose our arrangement over conventional programs, we will pay conventional, going rate "market prices" (to be maintained, calculated daily, on the one-payer system, which also will track and account for its revenues, down to the individual employee's level, so that they can "audit" their employers, on line; as well as see what going rates are). Providers will have direct access to those prices and can tell patients, up front, whether they charge more or less than the going rates. Thus a patient will know whether s/he will be subjected to any "co-pay", which arises and is the difference that the provider charges IF the provider greater than going rates.

(8) Providers may meet the known competitive prices and, if asked if they would do so by the patient, will submit bills to the arrangement at those negotiated prices. (8.1) If providers charge more than going-rates, it must be confirmed that the patient has or, with a degree of certainty, will pay the greater portion. If the patient turns out to be unable or is bankrupted by the extra charges, our arrangement should be reimbursed the pro rata relative amount suffered; that is, be repaid this amount by/from the provider. Providers who are willing and able to work with this, to contract accordingly, should be enabled to debit our arrangement for payments (the County's too). Post audits finding patterns of abuse (honest mistakes may be corrected, perhaps plus the cost of finding them), or direct information of abuse, as possibly reported from patients, are what should have severe and immediate repercussions to the providers.

(9) Should, in the longer run, the 10% rate prove insufficient, then (9.1) it will have to be increased OR employers may seek for the entire program - their partnership within it - to be ended. (9.2) On the other hand, if the 10% proves to be excessive (a more likely scenario, given reduction of the third party costs, currently of up to 30% of what we pay into conventional insurance, for their none-medical costs, expenditures and profits), then the employers may be paid a pro rata refund based on the resultant percentage in excess of what they paid in. This rewards them for having in-house

health activities for their employees and employee families, etc.

(10) Employees with health care incidents, however, who negotiate, see or use less than going rate doctors and providers, will participate in the "savings" for using those providers with the latest, less expensive care and technology that drives health care prices down for us, reducing the over-all, current going rates and benefiting our arrangement participants as a whole. (10.1) Note that they, patients and individual people, are the ones competing for prices against what insurance firms may negotiate. Thus, neither government "with deep pockets" nor our arrangement is competing with conventional, competitive insurance firms. Their market remains free to compete against the individual participants, and (10.1.1) may, for a fee, offer them coverage for greater than going rate prices and/or (10.1.2) may offer them rebates or "profits" ("a negative fee") for finding less expensive than going rate care in their behalf. Every one - providers, patients and insurers, clinics, labs, pharmaceuticals, co-ops, etc - remain free to set their own prices, agree or negotiate differences and to compete freely.

(11) Whether with either of the partners, of the County and private arrangement placement, it is tantamount that private records of patients and individual firms, payers or providers, be kept private, because these are not the business of Government or our state. We may and must release macro-numbers and data, especially where any spreading disease should be brought to attention of any medical "alert" agency. Clinical data, such as of hereditary or historic conditions, or reactions to drugs, also should be available or accessible to researchers (and without disclosing individual persons involved). Doctors and hospitals, if authorized by patients, will be allowed access to the authorizing patient's medical files, personal histories, prior diagnoses and what we have paid for in terms of treatments or drugs (the latter making it hard for a patient or drug abuser to get multi-prescriptions by going to separate doctors or persons permitted to make prescriptions).

Government and the partnered arrangement are reduced to a collection department for the revenues, accounting for and reporting its gross numbers, and "paying the bill", a cost that may be estimated to be in an area of 70 cents per member per month, rather than the millions and billions of costs incurred by our indigent care program and conventional insurance firms for none-medical purposes. In the long run, we will be able and will pay going rates, not only for indigent patients, but also for millionaires, who are free to choose surgeons who might charge 10 times the amounts of fellow surgeons (hmm, they might think twice about co-paying for such outrageous prices and go with the fellow surgeon's; but it remains of their free choice :).

Questions or problems not addressed herein will be answered immediately or as they arise if and when we proceed. Recognize that whenever we go into a new frontier, we must know "up front" that there are unknowns that must be dealt with as they arise (else, then, consider retreat), or it would not be a new frontier, would it? What you are about to commit to, I have not found to exist in any part of the modern world's many

health care arrangements. (1) Your inclinations and Questions on this? (2) What are your commitment positions and/or conditions for moving forward? (3) Shall we start with how you want a contract written for the partner who may be the third party pay arrangement? And, if you are to consult with counsel, you also may wish to consider with her the plausible law suits that our County may encounter from private sector people and entities, if you do not proceed with the arrangement. (4) by when will you respond? [Note, I also have prepared a press release and a survey for our community members, should you find such a things necessary before proceeding.]

Hillsborough Care, a Government Sponsored Entity. What it means.

Think of a structure like our Federal Reserve Bank system where a central bank, in conjunction with U.S. Government, sets policy that then shapes the financial activities of regional banks, thousands of smaller banks and millions of people.

However, in health care, we discover that an inexpensive system for $360 thousand can serve a million people and all the medical providers whom they may choose among. A mere $35 million hardware and software system can serve our Nation.

The system is comprised principally of an Accounts Receivable System for revenues and an Accounts Payable system to pay for health care related incidents. As such it will have two major Master Files, one for those who pay into the system and another for those who enter claims for medical payments. Hospitals could debit and be subject to post-audit controls with stiff penalties.

At the center are people and General Practitioners, the people's primary doctors who are licensed to treat or to refer patients to specialists for special treatment. Nothing gets done unless a licensed practitioner prescribes it. That's how things work now.

Workers only get value in the form of money in the market place, not by working in their homes nor by working as a child to grow up. Therefore and because business is the point of sale for workers, it only makes sense that businesses pay for the worker's health care and the health care of the paid worker's none-paid support and supply system of future workers and supporters. By definition, unpaid workers and children cannot pay for health care; they receive no income to do so. Businesses cannot use health incapacitated employees but need and should pay for healthy workers and their support. All need each other, and federal tax liabilities are reduced for workers when employers pay for care rather than when employees do so out of their wages.

And doctors and providers need to be paid. It is unfair to hold them to a Hippocratic Oath, that they should be paid nothing for treating someone in our community. And it is unfair to force them to accept payments that are less than true going rates. In fact, it is unfair for us to expect them to have to collect 20% from sick or dieing patients. Doing so sets off a series of economic forces that has turned health care into an upside down world, forcing volume over quality, hidden costs and a hysterical array of unfair pricing, incorrect incentives, as in drug prescribing, and third-party, none-medical expenditures that take as much as 30% away from our medical expenditures.

Through our system, Doctors and patients privately can audit each other, maintain their own medical records and family histories and see what's been paid by their employers (did my employer not pay in) or for the patient's medical needs (does the patient already have pain medications prescribed by another doctor?).

Creation of a Hillsborough Care Government Sponsored Entity will create untold benefits for care and have savings from $400 million to $700 million annually for our community, which, per general estimates spends in excess of $2 billion annually in health care. Note, "A risk not taken is the greatest risk of all; and daily, at every moment, we are paying for it."

Proposed Legislation for the local, Hillsborough County Indigent Care Program.

Far below is copied the existing INDIGENT CARE AND TRAUMA CENTER SURTAX that pertains the half cent (general) sales tax that sunsets in 2005.

According to its last paragraph, related, combined taxes may not exceed 1% for the above. The current half cent tax is insufficient to meet needs of our Indigent Care program, creating "crisis management" to eliminate items that, over the years, have been added to the otherwise successful program of care delivery, or now to reduce, counter-intuitively, the length of time that members may participate (being a member with regular check-ups and preventive care costs materially less over the long run, as compared with emergency treatment costs).

Therefore, a community need exists to increase the revenues and in a climate where mutual needs and partnering between our County, its constituents and businesses - employers - can and will meet that need.

Hereby it is proposed that a half cent (.5%) tax be charged by local employees for their work and services to employers, which the employers may directly pool into our Indigent Care program and record that such payments are made via their traditional "pay-stubs" to employees and to be accounted for (loaded up) into our Indigent Care system, where employees also confidentially may review each payment and all payments made in their behalf.

Based on the half per cent contributions, the data may serve as an index as to whether employees qualify for our Indigent Care program, which, combined with existing criteria, then will pay for the employee's health care incidents at the established indigent prices.

This half cent revenue should exceed $100 million annually, will meet our growing needs and "reserve" (money on hand) requirements, and, at the time of the sunset of our existing tax, may replace it and go to 1%, raising in excess of $200 million annually to continue the expanded, reach out program.

Furthermore, it is proposed that small employers voluntarily may participate in the program, paying an additional 4.5% of employee wages into it, if they do not have or cannot afford conventional health care coverage for their employees.

Furthermore, it is proposed that larger, incorporated employers who have employees, who are not qualified by the employer for health care, such as due to substitute, temporary, part time or contractual work, or during qualifying periods, contribute an additional 9% of such wages or service values into our Hillsborough Care program. Not only are such workers likely candidates for Indigent Care, but the larger employer contributions will afford for providers to be paid "going-rates" for their medical work, rather than the low, pre-negotiated Indigent Care prices that financially need to be made up for by providers.

Our County and its community partnership then begins to meet needs of low-income employee health care, such as for people earning under $8 an hour, and financial needs of our medical providers themselves.

In fact, it furthermore is proposed that employees of employing entities that provide conventional insurance be allowed an option to choose our County program for an additional 10% rate (unless the employer already has a better value, paying less and/or having relatively better coverage). Such employees, then, individually may compete against the conventional insurance firms and negotiate better than going rate prices themselves, whereby profits for doing so accrue to the employee rather than the conventional insurance firm.

Based on a full partnership within Hillsborough County, our community's savings will exceed $200 million and, more likely, approach $700 million. The greater excesses that may be paid into our partnership may be used in a combination to pay the healthcare industry "across the board" going rates (without a traditional 20% co-pay; co-payments arising only if patients choose providers who charge greater than going rate prices); to reduce employer rates or refund paid-in amounts; and to subsidize the people qualifying for Medicare. The savings arise from reductions of none-medical expenditures that currently take up to 30% out of health care expended funds, be they for bureaucracies or private segment costs, administration, sales, marketing, management, price negotiations and profits.

All data expressed in the foregoing are documented or based on existing data of our Indigent Care Program and private sector data. Greater returns of scale would result by the program being state-wide or, even more so, national. However, our county's health care crisis exists now, needs to be addressed now and needs to be solved now. Any effort to take this state-wide, or national, would have to assure that it could act in behalf of and as quickly as our County can.

Coincidentally, before completing the previous sentence, I learned that a black man under emergency treatment in our Indigent Care program passed away two days ago. A friend, a nurse, attributed his death, in part, to secondary care treatment that emerges when our Indigent Program is "at the end of the year" and running over budget or is no longer budgeted for. Half of America's black population dies before 65; identical to low-income people dieing early; but not so bad in context of treatment and early deaths of Native Americans. The issue is one of economics, and it is one based on impoverishment or abuse of people.

Our community partnership and health care initiative represents only a third of the financial economics involved in impoverishing people, stopping and correcting for it. Food and shelter are the other two third's issues. We trust, hope and pray that no legislator will stand in this initiative's way but, rather, will work with us on a "whatever needs to get done" basis.

---

[1](4) INDIGENT CARE AND TRAUMA CENTER SURTAX.-- **[Previous county legislation/smaple]**

[2](a) The governing body in each county the government of which is not consolidated with that of one or more municipalities, which has a population of at least 800,000 residents and is not authorized to levy a surtax under subsection (5), may levy, pursuant to an ordinance either approved by an extraordinary vote of the governing body or conditioned to take effect only upon approval by a majority vote of the electors of the county voting in a referendum, a discretionary sales surtax at a rate that may not exceed 0.5 percent.

(b) If the ordinance is conditioned on a referendum, a statement that includes a brief and general description of the purposes to be funded by the surtax and that conforms to the requirements of s. shall be placed on the ballot by the governing body of the county. The following questions shall be placed on the ballot:

FOR THE. . . .CENTS TAX
AGAINST THE. . . .CENTS TAX

(c) The ordinance adopted by the governing body providing for the imposition of the surtax shall set forth a plan for providing health care services to qualified residents, as defined in paragraph (d). Such plan and subsequent amendments to it shall fund a broad range of health care services for both indigent persons and the medically poor, including, but not limited to, primary care and preventive care as well as hospital care. The plan must also address the services to be provided by the Level I trauma center. It shall emphasize a continuity of care in the most cost-effective setting, taking into consideration both a high quality of care and geographic access. Where consistent with these objectives, it shall include, without limitation, services rendered by physicians, clinics, community hospitals, mental health centers, and alternative delivery sites, as well as at least one regional referral hospital where appropriate. It shall provide that agreements negotiated between the county and providers, including hospitals with a Level I trauma center, will include reimbursement methodologies that take into account the cost of services rendered to eligible patients, recognize hospitals that render a disproportionate share of indigent care, provide other incentives to promote the delivery of charity care, promote the advancement of technology in medical services, recognize the level of responsiveness to medical needs in trauma cases, and require cost containment including, but not limited to, case management. It must also provide that any hospitals that are owned and operated by government entities on May 21, 1991, must, as a condition of receiving funds under this subsection, afford public access equal to that provided under s. as to meetings of the governing board, the subject of which is budgeting resources for the rendition of charity care as that term is defined in the Florida Hospital Uniform Reporting System (FHURS) manual referenced in s. The plan shall also include innovative health care programs that provide cost-effective alternatives to traditional methods of service delivery and funding.

(d) For the purpose of this subsection, the term "qualified resident" means residents of the authorizing county who are:

1. Qualified as indigent persons as certified by the authorizing county;

2. Certified by the authorizing county as meeting the definition of the medically poor, defined as persons having insufficient income, resources, and assets to provide the needed medical care without using resources required to meet basic needs for shelter, food, clothing, and personal expenses; or not being eligible for any other state or federal program, or having medical needs that are not covered by any such program; or having insufficient third-party insurance coverage. In all cases, the authorizing county is intended to serve as the payor of last resort; or

3. Participating in innovative, cost-effective programs approved by the authorizing county.

(e) Moneys collected pursuant to this subsection remain the property of the state and shall be distributed

by the Department of Revenue on a regular and periodic basis to the clerk of the circuit court as ex officio custodian of the funds of the authorizing county. The clerk of the circuit court shall:
1. Maintain the moneys in an indigent health care trust fund;
2. Invest any funds held on deposit in the trust fund pursuant to general law; and
3. Disburse the funds, including any interest earned, to any provider of health care services, as provided in paragraphs (c) and (d), upon directive from the authorizing county. However, if a county has a population of at least 800,000 residents and has levied the surtax authorized in this subsection, notwithstanding any directive from the authorizing county, on October 1 of each calendar year, the clerk of the court shall issue a check in the amount of $6.5 million to a hospital in its jurisdiction that has a Level I trauma center or shall issue a check in the amount of $3.5 million to a hospital in its jurisdiction that has a Level I trauma center if that county enacts and implements a hospital lien law in accordance with chapter 98-499, Laws of Florida. The issuance of the checks on October 1 of each year is provided in recognition of the Level I trauma center status and shall be in addition to the base contract amount received during fiscal year 1999-2000 and any additional amount negotiated to the base contract. If the hospital receiving funds for its Level I trauma center status requests such funds to be used to generate federal matching funds under Medicaid, the clerk of the court shall instead issue a check to the Agency for Health Care Administration to accomplish that purpose to the extent that it is allowed through the General Appropriations Act.
(f) Notwithstanding any other provision of this section, a county shall not levy local option sales surtaxes authorized in this subsection and subsections (2) and (3) in excess of a combined rate of 1 percent.
(g) This subsection expires October 1, 2005.
(5) COUNTY PUBLIC HOSPITAL SURTAX.--Any county as defined in s. (1) may levy the surtax authorized in this subsection pursuant to an ordinance either approved by extraordinary vote of the county commission or conditioned to take effect only upon approval by a majority vote of the electors of the county voting in a referendum. In a county as defined in s. (1), for the purposes of this subsection, "county public general hospital" means a general hospital as defined in s. which is owned, operated, maintained, or governed by the county or its agency, authority, or public health trust.
(a) The rate shall be 0.5 percent.
(b) If the ordinance is conditioned on a referendum, the proposal to adopt the county public hospital surtax shall be placed on the ballot in accordance with law at a time to be set at the discretion of the governing body. The referendum question on the ballot shall include a brief general description of the health care services to be funded by the surtax.
(c) Proceeds from the surtax shall be:
1. Deposited by the county in a special fund, set aside from other county funds, to be used only for the operation, maintenance, and administration of the county public general hospital; and
2. Remitted promptly by the county to the agency, authority, or public health trust created by law which administers or operates the county public general hospital.
[3](d) Except as provided in subparagraphs 1. and 2., the county must continue to contribute each year an amount equal to at least 80 percent of that percentage of the total county budget appropriated for the operation, administration, and maintenance of the county public general hospital from the county's general revenues in the fiscal year of the county ending September 30, 1991:
1. Twenty-five percent of such amount must be remitted to a governing board, agency, or authority that is wholly independent from the public health trust, agency, or authority responsible for the county public general hospital, to be used solely for the purpose of funding the plan for indigent health care services

provided for in paragraph (e);
2. However, in the first year of the plan, a total of $10 million shall be remitted to such governing board, agency, or authority, to be used solely for the purpose of funding the plan for indigent health care services provided for in paragraph (e), and in the second year of the plan, a total of $15 million shall be so remitted and used.
[4](e) A governing board, agency, or authority shall be chartered by the county commission upon this act becoming law. The governing board, agency, or authority shall adopt and implement a health care plan for indigent health care services. The governing board, agency, or authority shall consist of no more than seven and no fewer than five members appointed by the county commission. The members of the governing board, agency, or authority shall be at least 18 years of age and residents of the county. No member may be employed by or affiliated with a health care provider or the public health trust, agency, or authority responsible for the county public general hospital. The following community organizations shall each appoint a representative to a nominating committee: the South Florida Hospital and Healthcare Association, the Miami-Dade County Public Health Trust, the Dade County Medical Association, the Miami-Dade County Homeless Trust, and the Mayor of Miami-Dade County. This committee shall nominate between 10 and 14 county citizens for the governing board, agency, or authority. The slate shall be presented to the county commission and the county commission shall confirm the top five to seven nominees, depending on the size of the governing board. Until such time as the governing board, agency, or authority is created, the funds provided for in subparagraph (d)2. shall be placed in a restricted account set aside from other county funds and not disbursed by the county for any other purpose.
1. The plan shall divide the county into a minimum of four and maximum of six service areas, with no more than one participant hospital per service area. The county public general hospital shall be designated as the provider for one of the service areas. Services shall be provided through participants' primary acute care facilities.
2. The plan and subsequent amendments to it shall fund a defined range of health care services for both indigent persons and the medically poor, including primary care, preventive care, hospital emergency room care, and hospital care necessary to stabilize the patient. For the purposes of this section, "stabilization" means stabilization as defined in s. (29). Where consistent with these objectives, the plan may include services rendered by physicians, clinics, community hospitals, and alternative delivery sites, as well as at least one regional referral hospital per service area. The plan shall provide that agreements negotiated between the governing board, agency, or authority and providers shall recognize hospitals that render a disproportionate share of indigent care, provide other incentives to promote the delivery of charity care to draw down federal funds where appropriate, and require cost containment, including, but not limited to, case management. From the funds specified in subparagraphs (d)1. and 2. for indigent health care services, service providers shall receive reimbursement at a Medicaid rate to be determined by the governing board, agency, or authority created pursuant to this paragraph for the initial emergency room visit, and a per-member per-month fee or capitation for those members enrolled in their service area, as compensation for the services rendered following the initial emergency visit. Except for provisions of emergency services, upon determination of eligibility, enrollment shall be deemed to have occurred at the time services were rendered. The provisions for specific reimbursement of emergency services shall be repealed on July 1, 2001, unless otherwise reenacted by the Legislature. The capitation amount or rate shall be determined prior to program implementation by an independent actuarial consultant. In no event shall such reimbursement rates exceed the Medicaid rate. The plan must also provide that any hospitals owned and operated by government entities on or after the effective date

of this act must, as a condition of receiving funds under this subsection, afford public access equal to that provided under s. as to any meeting of the governing board, agency, or authority the subject of which is budgeting resources for the retention of charity care, as that term is defined in the rules of the Agency for Health Care Administration. The plan shall also include innovative health care programs that provide cost-effective alternatives to traditional methods of service and delivery funding.
3. The plan's benefits shall be made available to all county residents currently eligible to receive health care services as indigents or medically poor as defined in paragraph (4)(d).
4. Eligible residents who participate in the health care plan shall receive coverage for a period of 12 months or the period extending from the time of enrollment to the end of the current fiscal year, per enrollment period, whichever is less.
5. At the end of each fiscal year, the governing board, agency, or authority shall prepare an audit that reviews the budget of the plan, delivery of services, and quality of services, and makes recommendations to increase the plan's efficiency. The audit shall take into account participant hospital satisfaction with the plan and assess the amount of post stabilization patient transfers requested, and accepted or denied, by the county public general hospital.
(f) Notwithstanding any other provision of this section, a county may not levy local option sales surtaxes authorized in this subsection and subsections (2) and (3) in excess of a combined rate of 1 percent.

citizen robert wirengard
6234 N. Falkenburg Rd./Hillsborough County/FL 33610; Tel. contact, 813-758-7595; fax, 813-612-9709; e-mail, rowireng@tampabay.rr.com

October 4, 2003

John Kalb, Office of Senator Graham
2252 Killearn Center Blvd.
Tallahassee, FL 32308

Dear John,

With regard to our conversations today and as agreed, please personally provide Senator Graham with the enclosure, which is a comprehensive package. An extra is enclosed for you.

On an item like transforming federal income taxes to a flat, equal pay-roll tax on employers, Dr. Milton Friedman agrees with me on that, and it is something that readily may be saleable to the public and both major parties in Congress.

Similarly, by converting the current legislative efforts on elderly prescriptions to the Open Market Care model (budgeting elderly from actual price averages of specific medications to purchase these themselves, involving no third parties), not only will affirm the model but also will improve over the favorable Canadian prices or health care program (our pharmaceuticals now spend 40% of their outlays on "marketing and advertising", not to mention that third party healthcare costs run close to 20%).

I would be pleased to assist you in working out any and all questions that might arise.

Sincerely,

R.O.Wirengard

Copy: Dr. Milton Friedman
Hoover Institution/On War, Revolution and Peace*
Stanford University
Stanford CA 94305-6010

Re: Open Market Care: U.S. Legislation and Pure Privatization Program

What we have here is Open Market, Fair Share Care that is deliverable within a year. When it is free, with a "hands off" government that stands for goodness and enforces the fundamental laws of fairness, equal treatment and goodness, itself, and expects these of the private sector, be not afraid. Fear instead our government's "hands on" position that, worse, is sharing our taxes with "hands on" corporations, something that worried Abraham Lincoln about what corporations, someday, might do to America. It is time to free persons, now, allow persons to manage themselves, and for government to transform its legislative focus to the personal responsibilities that come with freedom: no more abuse. It is time for persons who live by, hold and advocate freedom, equality and treating others as we want ourselves to be treated, to stand up and command Open Market Care from our legislators. It may seem a frightening proposal; but, time and again, throughout what is written herein, they are the frightening details that must be addressed clearly, with no room for ambiguity, or we will remain where we are, leading the world in war, not peace.

October 7, 2003
R.O.Wirengard
6234 N. Falkenburg Rd.
Hillsborough County, FL 33610-9491
813-612-9709 (phone/fax)/ 813-758-7595 (cellular phone)/rowireng@tampabay.rr.com (e-mail)

ITEM 16/Open Market Care: U.S. Legislation and Pure Privatization Program
(Dr. Milton Friedman felt a "concrete" proposal needed to be spelled out)

BY BOB WIRENGARD

To the legislative end and seeking forgiveness, Item 16 reads:

This Congress hereby declares its sorrow for the deaths, damages, hurts and unfair discriminations that it and all of its predecessors have perpetrated, knowingly or unwittingly, against individuals as well as masses of people; and, by this legislation, seeks to amend and make reparations to you and all. Our standard in future legislations, and to review past legislation, shall be as to whether such legislation meets with ideals of treating you as we ourselves want to be treated, were we in your shoes.

"It does not take a village. It takes two good people, not to be interfered with, by a village." - bob

America's Impoverishing Problems Need Real Solutions; and Our Congress, in a Revolutionary Motion, Must Legislate Now, to Have Mobilized Goodness by 11/2, 2004

Within the question is the answer: Why so many women on welfare? Why so many Afro-Americans or Indians, poor?

To those with trust and faith, who seek to pre-empt abuse by inciting care, letting free will prevail, responsibly and without another managing you - be he a big brother or his private corporation; and to establish the stage for world peace, through a fair, just and equalizing arrangement, indiscriminately, to deliver on a living wage; I need to know of you now, if I can count on you, your support and, should badness prevail, how we now can organize a revolution by 2/9/04, for the voting booth, on 11/2/04. Leaders could start now, by ending personal income taxes and billing a competitively fair payroll tax.

Foreword

"Americans always get it right...Once they've tried everything else." - Sir Winston Churchill (roughly)

But responding in kind,

"Well Sir, once again, we shall be the first to go where no man has been; except, perhaps, those others whom Brit's also might call uncivilized and heathen. Ah, for goodness sake, we still love you, bro', and money is not always for evil. For welfare and healthcare, government should serve only to assure that we evenly and fairly pay for them; and, privately, independent citizens should be paid equal dividends.

[No one can manage another better than one's self. And we do want to pay less for our systems, while never sacrificing quality.]

- u.s. citizen bob, treasurer, now seeking other officers, investors, owners, givers, volunteers and workers for:

Resistance Movement to Badness and to Mobilize Goodness, Inc.

6234 N. Falkenburg Rd/Hillsborough County, FL 33610-9491 U.S.A.

Also contact through 813-512-9709 (phone/fax); 816-758-7595 (cellular); rowireng@tampabay.rr.com (e-mail)

Contact same to join the nascent Good Party - not limited to registered U.S. voters, but for Foreign and Not of Age people and Felons, too; nor is there an allegiance requirement to vote any slate or party line. Bob will have no wage from this; which, given minimum wage laws makes him illegal. Nor does he expect profits, secondary to preferred stock holders, who should not expect to profit either.

U.S. Legislative Needs Hereby Made "Concrete" for the Open Market Care Proposal.

1. Minimum wage laws are hereby null and void; and employers, in light of the following taxation shifts, may make adjustments in the wages that they currently pay and in benefits that they currently pay for, but subject to their employees' acceptance. That is, no employee is obligated to stay with you, pending the outcome of your adjustments. Their wages and benefits may experience a reduction equal to the cash and benefit paid via government.
2. A living wage consisting of $9000 a year, for food and clothing, shall be paid independently from employers to each independent citizen of the United States of America, and the equivalent of $3,480 a year shall be pooled for "cradle to grave", Open Market Health Care, whereby independent citizens will be budgeted at actual, going-rates to afford needed health care products and services, including abortions, in accordance with current federal laws, although no doctor or hospital shall be required to perform them.
3. Foreign citizens working here shall have health care coverage while here; and the excess in pay-roll taxes that employers pay to us for them, beyond the health care coverage, shall revert to the nations of the foreign employee's origin, for their tax expenditures, and to alleviate our government's responsibility of paying them the $9,000 in annual cash.
4. Social Security, Medicare and Medicaid programs hereby are null and void. Persons who currently are subject to such may stay with them, but existing minimum wage laws, taxes etc. shall run their course with them. That is, the Open Market Care proposal, including for health care, shall not apply for them.
5. Personal income taxes and Social Security and Medicare contributions are null and void.
6. Payroll, profit and interest taxes shall be approximately 40% "off gross", or 67% "on net" and equal for all respective capital uses. For example, if an employer currently pays gross, $100.00, then 40% or $40 reduces the net "take home" to $60. Alternately, paying employees $60 net, then the 67% payroll will yield the same $40 taxes or government revenue; the same holds for profits; and on interest rates of, say, 2%, the 67% tax would add 1.34%, for a gross cost of interest to be 3.34%. Note that many employers currently provide health care plans which happen to run at 10% above their current payrolls and, thus, are not reflected in gross wages. Also, the payroll tax applies to bonuses, stock incentives and similar types of income that generally are special benefits for corporate officers. Again, these things may be adjusted between employers and employees to each's satisfaction. [Note also that the 40% is an approximate number, that a more accurate study than Bob Wirengard's needs to be made, calculating the effects or added revenues, particularly with reference to the interest tax].[Where reasonable equity exists for banks to have bad debt coverage, they shall not charge borrowers a risk associated premium or higher than market rates.]
7. A new federal tax also shall be considered, debated, calculated and decided upon - and which would be intended to reduce the above taxes by the same amount or by what currently and specifically is spent federally on our soldiers and armed forces (what does not go back to states or people). Our military serves not just for ideals of freedom and democracy; but, more concretely, they serve to protect the existing wealth of existing owners, be these land, oil or diamonds. It may be most practical to apply this tax - 40% off gross - only on and when capital gains are recognized (through the trade, sale or inheritance of such wealth/gains). The fact that our soldiers often come from the ranks of our poor and continuously protect wealth, this tax appears to have a correct, logical rationale. [Blue sky values no longer would be depreciable.]
8. No regional or cost of living adjustments shall be made by the Federal Government. All citizens, wherever located within the U.S. shall receive the same benefits, and the Several States are free to tax and spend as they may see fit to make any adjustments as they see fit. This is to balance possible state to state migrations by favoring or disfavoring no one through the federal level and to offset for those with richer lands. For those citizens that work out of our Federal jurisdiction, we direct that their nations of employment abide by our tax arrangement and pay payroll taxes to us. For our workers or any visiting U.S. citizen, they, too, will be budgeted to pay your providers according to going rates.
9. The items in #6 are taxes for using three primary forms of capital: human capital (built by families and society), equity/owners' capital and borrowed capital (monetary sourced forms of wealth). They are arranged to be equal so that the respective types of investments are balanced in taxation and do not

/

create arbitrage or market aberrations based on tax reasons. In the equity market, arguments may ensue about paying taxes on profits, as they arise, or on dividends as they are paid. In the case of dividends, then any stock value capital gains also shall be subject to the tax upon realization. In the borrowed capital market, aberrations may occur from foreign funds that do not charge a sales tax on same. Either foreign originated loans should be arranged to have similar taxation, in order to keep global playing fields level; or both equity and borrowed capital may have to be tax free, but subject to the taxation contemplated item #7. Independent and objective financial experts who are better at these things than Bob Wirengard should be consulted (Michael Mussa of the IMF and former advisor to then president Reagan; Nobel Laureate Franco Modigliani at MIT and of M&M theory; or Milton Friedman, Senior Fellow at Stanford. They literally may provide correct answers in a matter of days, if not hours.) In fact, all of Bob Wirengard's logic should be independently verified by experts, and any counter proposals that anyone might offer, concretely to address and solve the problem. But, insofar as people are dying early and poor people and unbalanced markets are suffering daily, time is of essence.

10. The U.S. Treasury and Federal Reserve Bank System's policy is herewith ordered to be a policy of targeting a zero rate of inflation.

11. The Social Security Administration hereby shall partner with the Internal Revenue Service and Federal Reserve Bank; and, within ten days identify optimal distribution locations from which all citizens' data may be collected, Social Security numbers assigned and estimated systems requirements in terms of on-going administration determined (once the system is set up and ready to run); this includes determining ways for identifying homeless people to get their $750 allocations and the possible, altruistic institutions that try to serve them with food and shelter; publish within 10 days thereof those single-payer set-up and administration requirements for public bids - identifying local banks, local government agencies, businesses, including insurance firms, and potential Multi Employer Welfare Arrangements to assure public notice to all; and that, within 10 days thereof, of the public notice, that open bids are due; and within ten days thereof select the optimal bid which then shall be the GSE/MEWA partner to, upon notification of their selection, work with the government and its criteria to start-up recording receipts from employers, records of change administration, and payment distributions, everything to be on-line and running within 90 days of such notice.

The $750 and health care, hereby declared inalienable and un-attachable, government agencies such as those of Family and Children Services that may seek financial reimbursements from any disparate, alienated and none-supportive parent may be provided records of such parents who obtain that $750 and/or health care in order that their other earnings or income may be attached for their child or children's support, and so long as such parents do not voluntarily do or work to do so, after this legislation is operative.

Furthermore, where states such as Florida have anti-competitive or legal barriers that over-ride Federal regulations as regards a MEWA, appropriate Federal authorities shall compel respective state legislators immediately to void such laws.

The IRS charter shall pertain to assurance of collections from employers and self-employed persons and that respective funds and accountings thereof go to the GSE/MEWA for correct disbursements and that the latter safe-keep individual, personal medical records, distribute monthly $750 payments to the registered, independent citizens, and pay medically or otherwise licensed entities per going-rates, which the GSE/MEWA also will continuously maintain, recalculate and publish on line.

The U.S. Treasury and its IRS also shall distinguish those tax revenues that are designated for United States armed forces or Department of Defense and their respective allocations.

Medicare immediately shall make easy and user-friendly Internet access for any private person to see its "allowable" price list, explain its codification in common instead of Latin or medical term language and, as well, categorize and simplify its complex of codes with that common language or its cross reference to the technical so that this then may be used for people easily to "drill down" and determine whether any medical provider has charged or, per their up front price disclosures, would charge them a relatively or irrationally (outrageously) high price.

12. The Robinson Patman Act hereby is amended to mean that the spirit against price discrimination shall apply to and be enforced relative to services, not just products. Furthermore, the Department of Justice shall be sanctioned for not enforcing this Act in recent decades against either our corporate, private sector or government purchasing agents who, hereby, are ordered to cease and desist such

activity; AND corporations shall signify their corporate status to citizens within in their names, including at places of their operations, public advertisements, and all solicitations, so that the public can readily distinguish whether they are dealing with private citizens or proprietors who personally stand liable for their activities, products and/or services, as opposed to entities that have the "corporate shield" protecting owners and stockholders personally from such liabilities; AND in all political advertisements, those paying for same shall publish their entity's full name along with the names of the principal officers of same so that these too may be readily recognized by the public that is exposed to such advertisements.

Individual licensed and personally liable people, but not corporations, may manufacture, wholesale, distribute and retail arms, and people may bear them. U.S. corporations may manufacture and deal in arms with U.S. government bodies only, and only so long as this is for government defense and peace-keeping purposes.

13. Public schools may provide elective courses that objectively teach about religions, beliefs, their histories and/or comparative religions; and students who seek to pray openly and in groups may do so at public school facilities, in kind as may be afforded other student groups, and that this similarly be before or after normal school hours and so as not to interfere with the state's obligations as regards education. No student or teachers or other staffs shall be made to feel unwelcome to such events nor welcomed not to participate.

14. The United States of America hereby establishes that the death penalty be null and void and invokes a spirit that people should not kill, be violent or damaging, steal or lie; but treat each other as each would want to be and to be personally responsible citizens.

15. The right of felons to vote is hereby reinstated; and any local legislative body that continues any prohibition of felons to vote shall be compelled not to tax such felons in any way, shape or form.

16. This Congress hereby declares its sorrow for the deaths, damages, hurts and wrongful or unfair discriminations that it and all of its predecessors have knowingly or unwittingly perpetrated against individuals as well as masses of people; and, by this legislation, seeks to amend and make reparations to you and all, for such damages, hurts and wrongful or unfair discriminations. Our standard in future legislations, and to review past legislation, shall be as to whether such legislation meets with the notion of treating you as we ourselves want to be treated or were we in your shoes.

Notes: Private Sector's Infrastructure Made "Concrete" for the Open Market Care Proposal

For the $9,000 a year distributions, to be made at a rate of $750 per month to each independent citizen, our government offices that already send Social Security checks or makes such electronic deposits can perform the task. If a private sector entity feels that it can do a better job of this, which may be the case with whoever handles the health care program, then that should be the case. Note that a Government Sponsored Entity (GSE), such as our Federal Reserve Bank, sponsored by our government but working independently, could have a bank be the single administrator of both the tax revenues from employers and the distributor of $750 and health care budgets.

The bigger problem pertains to government employed social workers, administrators and "gate-keepers" or authorities that no longer will be needed [this applies to the down-sizing of our IRS workers as well]. Plans of how they may be put to productive or socially valuable use in other work or jobs need to be studied and, where plausible, be applied so as to minimize their unemployment. Many might find the $750/month their ticket to enter our private sector, perhaps health care or become enterprising themselves; but certainly, it would seem, we need workers to tackle directly the growing social problems of drug and alcohol abuse as well as those of environmental or eco-system concerns. The latter are viewed to be the next layer of potential causes of world wars.

As to the health care proposal, we already have the doctors, hospitals, manufacturers, et al, in place in our private sector, but not the other truly "private" player, the one "one-payer system/center" independently to receive funds and disburse them while maintaining privacy and security of all medical

information, which should not be in the hands of any level of government. It privately may be established under ERISA as a Multi Employer Welfare Arrangement (MEWA); or, again as a Government Sponsored Entity.
We already have private banks with secure, private, personal accountings for people, payrolls and businesses, any of which could take on many, the majority or all of the revenues and funding operations of the proposal. Remember, the hardware needs are less than $200,000 per million people, and the also independently estimated programming cost to cover all 280 million Americans is less than $200,000 (a scratch start total would be $56.2 million for our entire Nation's health care administration setup, but most banks already have the hardware, so the total program's cost, then, would be less than $200,000). Within 6 months it can be tested and running, with employers uploading both employee wage data and the health care funds associated with each; and doctors and hospitals, as well; for whom each citizen could have a health care "credit card" and foreign workers, also.
Licensed doctors and hospitals could debit the fund with their submission of bills, be electronically paid or have checks cut to them. Post audits, including by patients, that find misbehavior and errors may be immediate, and patients may participate in the savings, penalties or recouped funds that result from such errors. Any post-audit recognition of patterns "of errors" or fraud should result in strong sanctions against the doctor or hospital, including but not limited to immediate withdrawal of licensing.
Doctors and providers will have to set their own prices and bill accordingly, with the caveat that they may not differ or discriminate in prices from person to person, although they may "meet competitive prices" that are lower than their prices. They may also simplify and bill at 10% above going rates, at going rates, or 10% below going rates (in which case the patient benefits, receives a check for the 10% savings, which then also reduces going rates).

"The merits, of 'Negative Taxes' and Open Market Care, are to socio-economics and natural sciences what e=mcc and the atom bomb are to physics, except that they are never violent or destructive." - bob wirengard

"How wonderful it is that nobody need wait a single moment before starting to improve the world."
- Anne Frank (young Dutch Jewish diarist of the World War II era)

"I see in the near future a crisis approaching that unnerves me & causes me to tremble for the safety of my country... Corporations have been enthroned & an era of corruption in high places will follow, & the money power of the country will endeavor to prolong its reign by working upon the prejudices of the people until all wealth is aggregated in a few hands and the Republic is destroyed."
- Abraham Lincoln (in 1864):

"Mankind must put an end to war or war will put an end to mankind."
- President John Kennedy (to UN on 9/25/61):

"We can best help you to prevent war not by repeating your words & following your methods, but by finding new words & creating new methods."
- Virginia Woolf (English novelist, 1938):

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."
- Margaret Meade (American anthropologist)

It does not take a village. It takes two good people, not to be interfered with, by a village. - bob

September 18, 2003

Hi Rob,
Long time... Thanks for all your mails. I print them out for the whole family to read.
I am now back in school. At university I take two separate English classes, one which focuses on the language and the other one focusing on USA (culture, society etc.) I also take philosophy, religion and geography...I have no idea what I'll do with it but I'm sure it'll come in handy at some point...
Well, this week we're looking into the politics and the government in USA and I thought, who could possibly know more about that than you?? So, if you have a few moments to spare I'd be ever so grateful...
Well, hope things are good with you and the rest of the family. I'm off to class.
Mvh, Noorah

*****

September 21, 2003

Dearest Noorah,
You are back to university! Congratulations. The learning, both academic and "street-wise", can make you into a prime minister.
Assist on an assignment about American politics and government? Of course, though, the few of my moments to do so result in a number of pages of historic perspectives for you to read, and a return assignment for you or anyone who chooses to do it. Much of what follows is both academic and of "street-wise" observations. [With a master's degree in finance only, i may teach in U.S. Universities, but not first graders.]
George Stephanopolous, who worked with former president Bill Clinton, defined American politics in terms of the Greek word "poly", meaning "many", and the American word "tics", meaning blood-sucking animals. We do survive through some dark humor, but the way our politics and government are going, we well and sadly may frighten not only many Americans but also your country and the rest of the world.
Politics and government have evolved with great ambiguity in America. While we openly proclaim that our brand of democracy is the greatest in the world, we privately say, "Do not discuss religion, sex or politics, and all will be fine." But all is not. Our founding document, the Declaration of Independence (from Great Britain), was in a culture where "men" really meant men and only white men at that; that women were not the final decision makers; that black people were property; and that Native Americans were "merciless Indian Savages" (insurrected against them by Britain's King George).
While the man largely credited with writing the Declaration, Thomas Jefferson, was of universalism embracing "Laws of Nature", he also wrote that "A woman rising with her hair unkempt is a slut"; and he rejected the supernatural and mysticisms of the Bible. He was not ambiguous, nor was the Declaration, and America has had to struggle since then for women and minorities, the smallest of which, which used to be 100%, is now the Native American.
Our presidents and nearly 100% of our Senate, which has to co-sponsor legislation with our larger House of Representatives, have remained "white male, American-born Christians"; the same criteria that defines a member of our Ku Klux Klan (KKK), which has expressed no ambiguity in declaring the white man's superiority as a race and actively showing their allegiance to Hitler's identical philosophy. The KKK is declining, but its philosophies are resurrecting, primarily from southern America, where people fought bitterly in the 1860's against our north's position to end slavery. [It is curious that in your country, where people looked alike, slavery was not fought over but became obsolete, and its laws were not taken off the books until the early twentieth century].
We do not have a pretty picture here, in the "land of the free" and "the home of the brave"; but it is with clarity and no ambiguity that i must continue, or you would not understand and accept our current political scene and our current government's, both left and right wing's, miss-direction; and, as such, i carry the same harshness as that which comes from any truth.

I ran for local office; and, in terms of what politics here are not, is neither American nor Christian. They systematically will steal, interchange or run over your little political signs with 4x4 vehicles - both major parties will do these things, systematically meaning not in mischief, which might be considered American. They are not doing these things in mischief. Both major parties are un-American.
And what i call "evil Christians" have infiltrated the Republican party to become the front-runner, "majority", "ruling elite" consisting primarily of white, male, American born "Christians". They are not Christians, because they are versed in the Old Testament teachings, generally punitive or punishing, and their assertion that they are Judeo-Christians is an oxy-moron (like jumbo shrimps or gentlemen-of-the-courts lawyers). Christ might say, "Go forth and sin no more"; but these people want capital punishment, prisons and vengeance with a blood-money-passion that goes way beyond even an "eye for an eye" of the Old Testament (an "eye for an eye" was supposed to be an upper limit, not be two for one; and was exceeded in our war against Afghanistan); and, ultimately, these "Christians" seek to usurp our government, to place their "God" over this Nation (no more separation of church and state, in deed that their church should rule). Ironically, the Republicans are working under a notion that they must serve the minor fundamentalists or their votes will go to the Democrats; but that is a hypothetical miss-judgment: if Republicans did not cow to the "religious" plank, where would such backers turn to? Not to the democrats, at least not insofar as their plank would be moot there, as well; and, if they started their own party, it might go in the direction of the KKK, becoming obsolete, or just take a few votes from the Republicans, like the Green Party's took a small 2% away from the Democrats, adversely affecting their principles in common. Republicans are miss-guided.
Democrats, generally associated with the working man and poor people, have abandoned the poor, which consists in large part of black people (and Hispanics, today). While blacks have gotten into our House of Representatives, they have not succeeded in the Senate, which makes their issues moot: co-sponsors are needed in both the House and Senate in order to initiate a legislative bill. Not even white Democrats in the Senate would co-sponsor the black caucus' effort from the House to challenge our now president Bush's election. Democrats also have been split by "far left, self-righteous eco-people" forming their own Green Party.
Thus we have minority, special interests succeeding in or trying to get to run our country; the one leveraging itself among Republicans, the other dividing Democrats. The huge irony of a true democracy - which we irrationally insist to ourselves and the rest of the world that we are - being that not just a minority but everyone should agree, unanimously, on any legislative decision. Instead, we have a tiny minority of Old Testament fundamentalists now, who call themselves "Christians", like wolves in sheep clothing, usurping with their agendas, and despite our charter of separating Church and State, all the way up to our current president, with a full regalia of us wrapping ourselves in our flag and asserting "God is with us" (not the rest of the world).
The relatively tiny "Christian" minions either are out-right liars or have not carefully read our historic Declaration of Independence. That is, they claim that America's greatness is the result of our Christian doings, but our Founding Fathers, who represent our true history, wrote in our Declaration of Independence and referenced Nature's Laws, Nature's God and our Creator, clearly and specifically ruling out Biblical, Old Testament and Christian preferences. In fact, the man who largely is credited with penning the Declaration of Independence, Thomas Jefferson, later was considered an "infidel" by the Old Testament fundamentalists, and their brow-beating and stigmatizing against anyone, especially their aggressive and twisted assertions that no one is a Christians unless they accept their fundamentalist beliefs, has taken its toll over the past two centuries. It now has culminated in recent wars and American "Christians" going to Iraq to convert (heathen/infidel) Muslims. As i have mentioned before, Mr. Jefferson also edited or wrote his own Bible, taking out the supernatural and mysticisms; but i also stress that we have our Judeo-Christian link to Israel, where Zionists may be mirrors of our "Christians", going in league against the Arab-Muslim world that in turn sparks terrorism against both Israel and America.
Our Government, mainly Democrats and Republicans, has created an "Home Security" system for our entire Nation now, based on a dark September incident. But it occurred after we, America, told Afghanistan nine months earlier that we wanted an oil pipe line through it and for its current administration - which had fought Russia bloodily to get control - to step down and be succeeded by its predecessor leadership (and America had trained the Taliban!). No one seems to realize that, when

cornered, even the tiniest mouse will attack the strongest, fastest cat known; go down fighting rather than dieing without struggle or signaling their distress to the rest of the (Arab-Muslim-Shiite) world. So there you have it: a punishing, against women and violent world of Shiites, Zionists and a minor minion that calls itself Christian, each a minority but with identical and respective philosophies of supremacy, dividing and conquering good Islam, good Judaic and good Christian people. Our wars are based on bad religious people insidiously working within good religions, push the respectively good proponents out, and so as to usurp any semblance of good government and rule the world.

No one seems to appreciate or lost is the fact that America's true greatness is rooted in our freedom, our "hands off" government that allows for free enterprise, free thinking and one's own capitalization (your money, not another's nor the government's should burn or be lost, if you fail). Our capitalism is a hard stand and one that has separated our Nation from many nations; but others, the ones adapting our "hands off" position, are now economically equal to or even better off than America. It is a smaller government that gives for happiness, free spirit and greater accomplishment; not a religiously based one or dictatorial one. Treating others as you would be is not only the "golden rule" and universal among people of "no religions", as well; but it also underlies a capitalist economy's society: you are free to run your own business, to lose or gain, so long as you treat others fairly, compete equally and hurt nothing; or, in short, treat others as you would be.

Democrats and Republicans in America and internally are now at war with each other, cutting each other up, figuratively speaking (although the stabbing to death of the Swedish proponent of the Euro v. the Krona - did she also oppose the war in Iraq? - makes for literal concerns). We literally are in a hate mode, at each others' throats and tearing apart. It's so twisted that our Government, through our Home Security act, claims that we, the people, are the ones not to be trusted; and, rather, that it is the Government officials who should lead and be trusted: when president Bush said that our State of Union was the best ever, both sides of the aisle stood in ovation. And looking at the huge sums tied up in our welfare, Social Security and Medicare programs, our Republicans, rather than solving the underlying problems of these and minimizing government, have talked the Democrats into splitting the administration (governing) of those sums and revenues (Americans are "privatizing" our government's administration to corporations, rather than to individual, private citizens; for corporate profiteering, and are splitting the booty with Democrats' acquiescence).

Our politics are upside down and religious fanaticism has played a profound, deep role. Christ was not a leader; instead, he was one who had followers. People came to him of free will and were left by him to behave in free will; letting each's wizened conscience rule. We Americans, today, have to follow, whether we like it or not, obey orders and observe rules or be fined, penalized or imprisoned. Political parties rule, not our conscience; and we are made to abdicate our own freedoms, religions AND responsibilities.

Underneath it all are the unreal, hypothetical arguments that, when examined more closely, do not hold true to life. Iraq could have had atomic weapons, but our intelligence said no; and Hussein, if he would not step down as ruler, like Charles Taylor of Liberia did, then he could have been brought to task to end atrocities through peaceful means, just as he had, it's now born out, done away with weapons of mass destruction. We are not rational. Locally, our school board invoked the right of teachers to paddle students ("spare the rod and spoil the child"), but many people the world over, and schools, successfully raise children to be good, learned and productive grownups, without ever a slap. Plus, they are happier for it, because we see that those who were beaten develop hatreds and, having learned that beatings are the way to go, perpetuate the brutality and hate through beating others. The fact is that more than 70% of our men do not beat their wives; and, where we do not, we live happier lives. And facts include that Iraq and Hussein stood against Shiites, and did have universal health care that may have saved more Iraqis than the 100,000 annual deaths that America attributes to poor health care delivery in our United States. Our deaths are not hypothetical; and death counts as measures of who is the most atrocious may very well now create ambiguous feelings.

But it remains that we are called un-American and none-Christian if we do not pledge allegiance to the State (or do not say "under God" now), while our Founding Fathers did brake allegiance and went to war, declaring it our "duty" to do so, when any government becomes over-bearing or tyrannical, the measure of which today remains government breaches of the Founding Fathers' Constitutional amendments, the rights of people (not to be interfered with, managed or policed by or dictated to by

government). Yet, in the pure paradox throughout all of this, we have a vast majority of good Christians in America who say prayers at home, in churches, with friends or silently, not aggressive and never wearing their religion on their sleeves, like the Old Testament "Christians" who are succeeding, miss-leading and influencing us to bring their form of "church" above our State. In fact, i have found that a number of Americans who do believe in God do not, under closer examination, really "Trust in God", confirmed in a sense by many people leaving our northern shores, before hurricane "Isabel" arrived to take lives.

Supposedly, today, we can "overthrow" governments through our voting booths, our highly touted democratic elections. But we saw not only our Supreme Court decide Mr. Bush should be president through Florida's fiasco (from running over signs to not being prepared for a large turnout of voters in poor neighborhoods, many going home without voting; or allowing American-Israeli's extra time for their ballots to arrive back to Florida, the U.S.); but we also saw that poor, who largely comprise our 2 million prison population, denied their unalienable rights - and "duty" - to vote. And despite denial of felons to vote, we tax them every which way as anyone (in America, we are not supposed to have taxation without representation; that is, be denied voting rights needed to overthrow to elect new representatives). But that's what we have done; and it's as though we have made poverty itself illegal, and through twisted processes that are not solving but perpetuating it.

You get the points/hints? We have not solved poverty, and despite Christ's operative of admonishing about sin, to "go forth and sin no more"; we lock up and, as well, execute people, primarily the poor. Yet the fact remains that neither sin nor crime has declined, no matter how many poor people we lock up (America has the highest rate of prisoners in the world; greater than China, Russia or Iraq's!). We must look to other ways of solving such problems, and separately in families and communities, not through legislation or State; and including on the issue of abortion. And the fact that up to thirty per cent of our women are abused, when placed beside the fact that most people on welfare are women; this is a very sad reflection on our "men" and male leaderships (who largely get "entitlements" and workmen's compensation rather than "ugh, welfare"). Women are secondary citizens here, in America, today; and when an adulteress was brought before Christ two millennia ago, he well may have noted that the adulterer was not also brought forth. Underlying his posture to "go forth and sin no more" was an intuition or insight that men are unfair, this on top of the fact that imprisoning or penalizing them would not solve the problem of adultery (nor of prostitution). And in the Good Samaritan having achieved some wealth, Christ did not hold the wealth against him (he may have been a man who well worked his own farm in order achieve his wealth and be able to help the robbed victim, even pay in advance for his keeping and treatment at an inn).

Yet the key for our division, that we Americans should stand united for, not divided, rests in the simplicity that Republicans and Democrats need to come together: business and workers do need each other. Lacking either, our economy would not progress or go anywhere; and our average longevity might still be close to 40 years, as it was merely a hundred years ago, not much better than in Christ's days, rather than close to eighty, as it is today, among the white Americans, that is. (All, of course, unless we really do not mind returning to the harder and closer to nature days; which we are free to do, perhaps by going to Lapland and joining Sames; or Alaska, Eskimos).

And, as one of our mutual relatives wrote to me years ago - Torsten, "retired" diplomat and former worker within the United Nations - trust is the most critical ingredient in diplomacy, working together. Trust in the good things of our respective Democrats' and Republican parties is what needs to be the medium and solder that bring and keep us together, and our government needs begin to trust in all American citizens again. Our grocery stores are open market, with people being trusted to come to a check out counter and pay for the goods, rather than walk out the door, stealing them. We reciprocate in the trust and know that stealing is wrong. And whatever petty theft that does occur, is far less in cost than maintaining a spying eye or police force on us...i do not know what the cost of the Home Security act will be, but we do know from a Harvard study that more than 20% of waste occurs and results from our administration and "policing" of health care (that a doctor not perform unauthorized treatment, makes administrative errors or submits a fraudulent bill). Being distrustful is counter productive and very expensive. [And note that, while there has been one infamous "Bobbitt", and while so many millions of American women suffer abuse, there has not been an uprising at night with many or all stabbing their trustfully sleeping husbands to death.]

And what is bad in each party must be cut out like any insidious, evil cancer. But, as with cancer, our people have to go through its five psychological stages, before "dealing with it" becomes realistic. Those stages are first denial, then anger, bargaining, "depression and sadness" and, finally, acceptance, before we can begin to deal with the problems.

We no longer may deny that poverty exists in our wealthy Nation and that they are our own systematic processes of impoverishment that create poverty. Given that earth belongs to everyone and has more than enough for to feed all, no one actually is born poor. They are impoverishing, self-righteous processes that ultimately border off a rich acre of land from one person to another getting none, that create poverty.

Americans automatically become angry with the above assertions and might claim, "We worked hard to get what we have, and any citizen willing to work hard can accomplish the same thing." They seem to think that "some" people are lazy and do not see that we have idle people all over our land who would love to have "forty acres and a mule" to work with vigor, care and love. But our poor do not have this, such a good thing, or "God's Little Acre" dream costing close to a half million dollars these days, just for good, rich land. One should not be angry that another has been denied space on mother earth. That is, on close examination, a self-centered, self-righteous and irrational anger.

And reading the above, truly understanding it, Americans sincerely may bargain. "God, please undo what we have done and i forever will be yours", or "Let's give something to the poor, but not a fair share, for that might make me insecure".

Which, of course, upon sober reflection leads us to the "depression and sadness" stage, for neither the prayer nor the giving of a little, even a lot for a moment, will solve the problem, the poverty or our impoverishing processes. They will not go away so long as we continue fundamentally what we have been doing for some 200 years, or, at least, since we actually gave people who came to America land, for free, and on which they were empowered to and did pursue happiness. (Although this was at the expense of Native Americans, and an identical process of impoverishing them of their land, through violence and rather than buying it). We did welcome "poor and huddled masses" from Europe for quite some time, but today prefer the ones with wealth and high skills, not Hispanics or our neighbors of Mexico (but will exploit their cheap labor, benefiting virtually all Americans). Well, you know yourself that many Europeans no longer seek to emigrate to America, or from many other nations (there are Russians who love Russia, as much as we love our homeland!).

These are depressing and sad things, just alone to think what we have done to Native Americans, some of their Indian Nations, today, relegated and concentrated into "reservations", being among the poorest in our world and with "butcher shops" for their health care clinics. And at an opposite extreme, other Native Nations have become wealthy and rich at the cost of their own people's cultures: they exploit vices of gambling and none-taxable cigarette sales, and their Chiefs are no longer women. Their leaders are no longer without sins themselves. In fact, we are at a point in our economy where the signs indicate we are polarizing into an upper and lower class, with the middle class thinning out and going either to the upper or lower: in the past two years, those earning less in real dollar terms than before, reached up to our median income earners (in the previous thirty years war on poverty, it was the lowest twenty per cent of income earners who were earning less). Sad, but true.

If and only if we begin to accept all of the above as facts, then we can begin to deal with the problem of poverty, impoverishment and America's not-so-secret shame of it, in realistic ways.

The most realistic and only way for us to overcome poverty, while maintaining America's idealisms of individual freedom and free enterprise and that wealth building is not necessarily bad, which demand smaller and "hands off" government (as opposed to socialized medicine, more taxes or "big brother or sister government" trying to manage our lives for us), is simply to pay each and every independent citizen, now rich or poor, including Native Americans, $750 monthly for each's food and shelter needs. And, second, to pool funds from which each will get a budget to spend on our own health care when needs arise, "cradle to grave" (if you choose a doctor who charges more than the budget, then you co-pay the extra; if s/he's the budgeted "going rate" you co-pay nothing; and, if someone charges less than going rates, then you keep the difference form the budget, for being a "wise shopper"). Your nation and every nation could do the relatively same thing, pay each independent citizen the minimum costs for food and shelter and pool funds for the health care, at the respective currencies and going rates of your country.

nation and every nation could do the relatively same thing, pay each independent citizen the minimum costs for food and shelter and pool funds for the health care, at the respective currencies and going rates of your country.

But your question is about American politics. Will it cost us more? No. When we down-size "the management" and take the responsibility to manage on our selves, buy our own food, shelter and health care, we will have material economic savings from that down-sizing. But more important, when we raise the economy of our poor, to get food, shelter and care, the result becomes that everyone's economy rises; socio-economic interdependence proliferates and makes growth progressive. And possibly more important than that, we no longer are dependent on anyone, will have to work of free will and free choices, to be responsible for our selves. One no longer will be able to blame the system for one's economic miseries. We would be free to accept anyone's advise, but, even in doing so, should a problem result, it is of our own doing! When we "burn a bit, we learn a bit", and pretty fast. We lift from the sluggishness of socialism that our poor must now endure - ordered to be patient, idled and waiting; made to feel worthless, depressed or angry - and any personal need (although not want) to steal or prostitute for one's own survival is eliminated: one is empowered to act on one's own, be enterprising and work for other things than "hand to mouth" survival. In short, move from a subsistence level of trying to survive, to thrive.

From our economically oppressive politics, government and systems, a socio-sexual phenomena will emerge. This upshot has been observed and captured in what happens in third world nations where women are provided micro-loans that average $100 and have a better than 98% rate of full repayment. One of the women gaining economic sustenance, financial independence, spoke and said to the effect, "Understand that the value goes beyond economic. My husband has done an 180 degree (social) turn, no longer stays out drinking and keeping in charge of the income - I have my own now; and he comes home, helps with feeding, nursing and teaching the children and no longer abuses me." A woman having her own wherewithal cannot be accused by a man, rationally, that she is not good; coming together, working together and partnering for overall betterment - human values - is the opposite of oppression, tyranny and being made into a secondary citizen.

Much of the above $750 solution is based on Dr. Milton Friedman's "negative tax theory" (what people get apportioned back from taxes) and with whom i have had the honor of correspondence (as a Nobel Laureate in economics, he also is considered by many to be "the" economist of the twentieth century). He pointed out to me that i have not put forth a "concrete" proposal of how to achieve my objectives of the (universal) Open Market Care model, which is what i call the $750 and open market health care. Well, here comes another beauty about American politics, government and legislation: by the powers vested in our United States Congress through Amendment 16 (somewhat unconstitutional; more dark humor?), our Congress may tax and spend in any way it wants.

This means that our politicized Congress could pass legislation this very day, today, and in a matter of hours, that would enact my concrete proposal for our government to carry out. Thus i copy below a draft of my "concrete" proposal to wonder if you or anyone might note anything that's been left out, should be added or changed, in order for us to defeat poverty in America and begin a better world (or from your own nation)?

i return your "mvh", as brother Bernt told me its meaning, in kind, with most warm greetings from Florida, the Sunshine State of America.

Uncle Rob
Bob Wirengard
6234 N. Falkenburg Rd.
Hillsborough County, FL 33610
813-612-9709 (phone/fax)
813-758-7595 (cellular)
rowireng@tampabay.rr.com (e-mail)

WHERE WE STAND

THE LEAGUE OF WOMEN VOTERS

Creating a Just Society

Health Care

Position in Brief:

Promote a health care system for the United States that provides access to a basic level of quality care for all U.S. residents and controls health care costs.

WHERE WE STAND

THE LEAGUE OF WOMEN VOTERS

The League's Position

Statement of Position on Health Care, as Announced by National Board, April 1993

GOALS: The League of Women Voters of the United States believes that a basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.

BASIC LEVEL OF QUALITY CARE: Every U.S. resident should have access to a basic level of care that includes the prevention of disease, health promotion and education, primary care (including prenatal and reproductive health), acute care, long-term care and mental health care. Dental, vision and hearing care also are important but lower in priority. The League believes that under any system of health care reform, consumers/patients should be permitted to purchase services or insurance coverage beyond the basic level.

HEALTH CARE ACCESS RESOLUTION

House Concurrent Resolution 99 (H. Con Res. 99) & Senate Concurrent Resolution 41 (S. Con. Res. 41)

Directing the Congress to enact legislation by October 2005 that provides access to comprehensive health care for all Americans.

Whereas the United States has the most expensive health care system in the world in terms of absolute costs, per capita costs, and percentage of gross domestic product (GDP);

Whereas despite being first in spending, the World Health Organization has ranked the United States 37th among all nations in terms of meeting the needs of its people;

Whereas 42,000,000 Americans, including 8,000,000 children, are uninsured;

Whereas tens of millions more Americans are inadequately insured, including medicare beneficiaries who lack access to prescription drug coverage and long term care coverage;

Whereas racial, income, and ethnic disparities in access to care threaten communities across the country, particularly communities of color;

Whereas health care costs continue to increase, jeopardizing the health security of working families and small businesses;

Whereas dollars that could be spent on health care are being used for administrative costs instead of patient needs;

Whereas the current health care system too often puts the bottom line ahead of patient care and threatens safety net providers who treat the uninsured and poorly insured; and

Whereas any health care reform must ensure that health care providers and practitioners are able to provide patients with the quality care they need: Now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), that the Congress shall enact legislation by October 2005 to guarantee that every person in the United States, regardless of income, age, or employment or health status, has access to health care that --

1. is **affordable** to individuals and families, businesses and taxpayers and that removes financial barriers to needed care;
2. is as **cost efficient** as possible, spending the maximum amount of dollars on direct patient care;
3. provides **comprehensive** benefits, including benefits for mental health and long term care services;
4. promotes **prevention** and **early intervention**;
5. includes **parity** for mental health and other services;
6. **eliminates disparities** in access to quality health care;
7. addresses the needs of people with **special health care needs** and **underserved populations** in rural and urban areas;
8. promotes **quality** and better health outcomes;
9. addresses the need to have **adequate numbers of qualified health care caregivers**, practitioners, and providers to guarantee **timely access** to quality care;
10. provides **adequate** and **timely payments** in order to guarantee access to providers;
11. fosters a **strong network** of health care facilities, including safety net providers;
12. ensures **continuity** of coverage and continuity of care;
13. maximizes **consumer choice** of health care providers and practitioners; and
14. is **easy** for patients, providers and practitioners to use and reduces paperwork.

Nurse Alliance of Florida

United for Our Patients and Profession

Safe RN Staffing Saves Lives....

September's *Reader's Digest* describes the RN staffing shortage that exists in most of our acute care hospitals as "The Biggest Crisis in American Health Care". Within the last year, authoritative studies have been published which conclusively link inadequate RN staffing levels to increased chances of patient mortality. A University of Pennsylvania study led by Dr. Linda Aiken and published in the Journal of the American Medical Association (JAMA) last October, established that every patient added to the average RN assignment in a hospital Medical/Surgical Unit more than the four patients who could be safely assigned increased the chances of patient death from routine procedures by 7%. Maintaining quality care is reason enough to address the crisis in RN staffing levels, but there is a strong economic factor that impacts even on the cost of medical insurance.

And Will Save Money Too....

California is expected to implement mandatory RN staffing ratios this January. Already, Kaiser-Permanente, one of the largest providers of health care in the state has voluntarily adopted staffing levels consistent with the 1:4 RN to patient ratio in Med/Surg recommended by the University of Pennsylvania Study. Kaiser reports patients are recovering sooner with fewer complications. Nurse attention means more rapid response to changes in condition. California expects to save 1 Billion dollars based on shorter hospital stay alone.

But Where Would the Nurses Come From?

What most people don't know is that the nurses are already in Florida, licensed as RNs, ready to go to work. Over 40% of registered nurses have left acute care hospitals, some 20% have left the health care profession, but less than 1% have left the workforce. The most common reason given for leaving work in the hospitals is that RNs are assigned too many patients too often. Safe staffing levels will bring RNs back!

Support Safe RN Staffing Ratios in Florida

Nurse Alliance of Florida, 1525 NW 167th Ave., Miami, FL 33169, www.nursealliencefl.org

BUILDING UPON PARTNERSHIPS TO ADDRESS AFFORDABLE HEALTH COVERAGE

November 2003

David P. Rogoff
Director, Health and Social Services, Hillsborough County
Phone: 813-301-7344 Email: rogoffd@hillsboroughcounty.org

THE MAJOR GOAL OF ADDRESSING THE UNDERINSURED IS:

INCREASE RETURN ON TOTAL COMMUNITY INVESTMENT.

NOT TO:

ACHIEVE DESIRED DISTRIBUTION OF FISCAL RESPONSIBILITY

TO INCREASE RETURN ON

TOTAL COMMUNITY INVESTMENT COSTS TO PROVIDE CARE MUST BE REDUCED

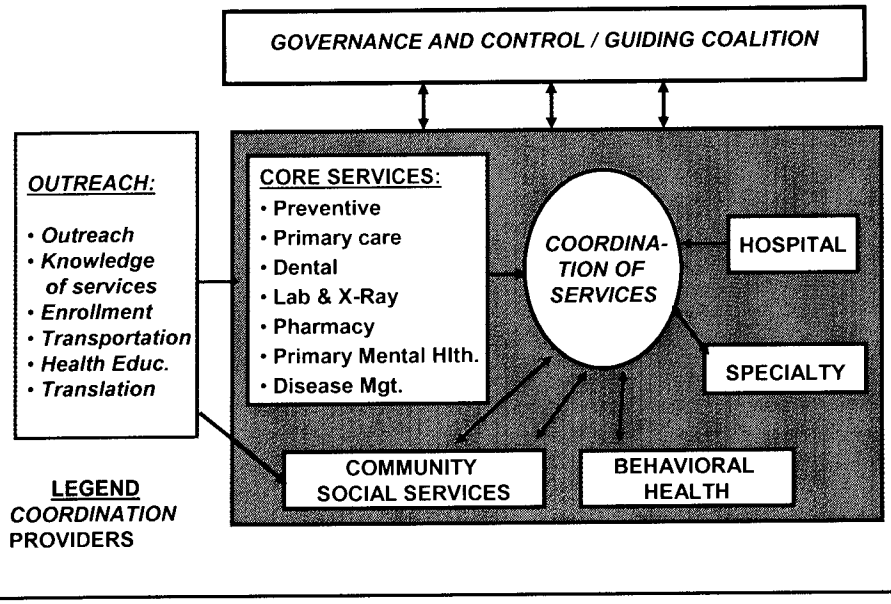
COST OF AD-HOC UNCOORDINATED HEALTH CARE SERVICES FOR UNDERINSURED PATIENTS

(AMOUNT PATIENT CANNOT PAY)

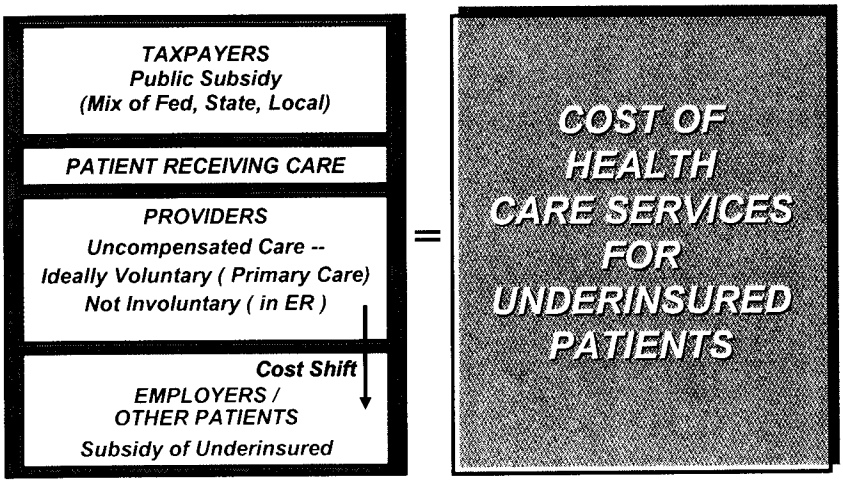
COST OF COORDINATED HEALTH CARE SERVICES FOR UNDERINSURED PATIENTS

(AMOUNT PATIENT CANNOT PAY)

COORDINATED HEALTH CARE REDUCES COSTS



CHALLENGE: DESIRED DISTRIBUTION OF FOUR SEGMENTS THAT BEAR COSTS OF THE UNINSURED



+ OUTSIDE FUNDS(WORKS FOR START-UP BUT NOT ONGOING OPERATIONS)

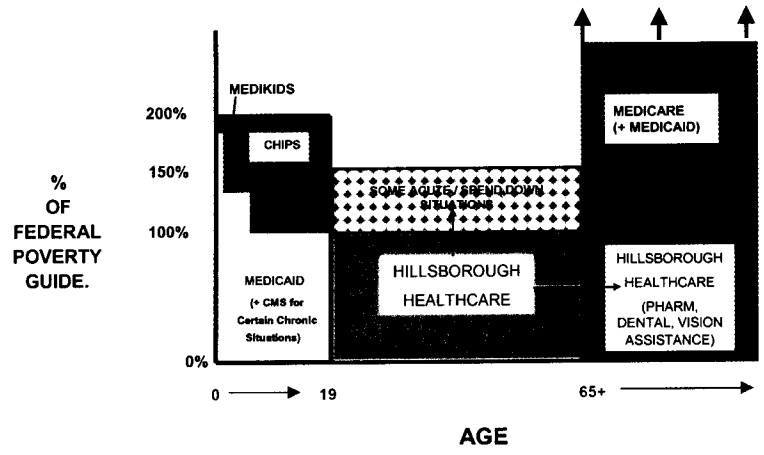
OVERALL GOAL:

DEVELOP PARTNERSHIPS AND IMPLEMENT STRATEGIES THAT BEST TAKE ADVANTAGE OF THE STRENGTHS AND CONTRIBUTIONS OF THE KEY PLAYERS

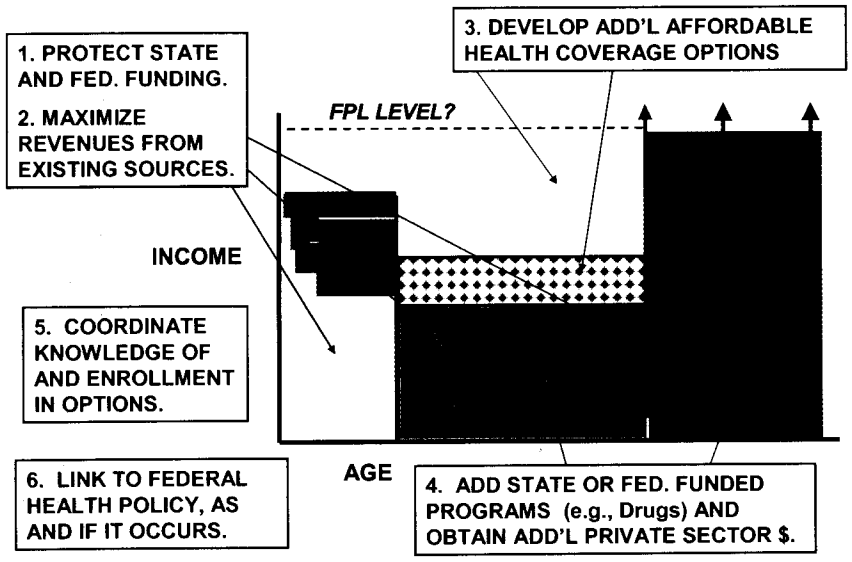
GENERAL STRATEGIES

- ***LONG TERM:***
  Solving the Uninsured Problem will Require Federal / State / Local, Employer, Private Sector, and Individual Solutions.
- ***SHORT TERM:***
  While the Economy May Not Allow Solving of Problem, State Goals Must Be to Keep Situation from Worsening and Have Some Improvement. Must Combat Trends:
  - **-- No. of uninsured in US: Increased 5.7% in 2002.**
  - **-- % FL people in poverty: Increased from 11.8% in '00-'01 to 12.6% in '01-'02.**

LINKING OF THE HILLSBOROUGH HEALTH CARE PROGRAM WITH OTHER STATE AND FEDERALLY SUBSIDIZED HEALTH INSURANCE (By Age and Income)



STRATEGIES TO FILL THE GAPS IN HEALTH CARE COVERAGE AND COORDINATION (SEE ATTACHMENT 1 FOR EXAMPLES)



DEVELOP SPECIFIC FUNDING STRATEGIES THAT BUILD UPON STAKEHOLDER EXPECTATIONS AND INCREASE THEIR DESIRE TO FUND

CATEGORY	SPECIFIC GROUPS	EXPECTATIONS
(A) FUNDERS	• Current funders - Providers. - Gov. (local, state, feds.) - Private sector. • Potential funders: - Continued funding. - More from current funders. - New funders.	➢ Benefits > risks / costs. ➢ Return on investment. ➢ Prudent use of funds. ➢ Legal. ➢ Accepted processes. ➢ Better off with program.
(B) CUSTOMERS	• Specific target segments. • End-Users (Insured and uninsured). • Their representatives: - Insurance carriers. - Business. - Government - Advocacy groups.	➢ Ease of financial access. ➢ Convenience. ➢ Customer satisfaction. ➢ Better off with program.
(C) INDIRECT BENEFICIARIES	• Government. • Society on the whole. • Health Depts. • Providers (incl. match.)	➢ Access to services ➢ Understanding of benefits. ➢ Better off with program.

STATE SUPPORT FOR ABOVE STRATEGIES

- ***ASSIST LOCAL GOVERNMENTS IN OBTAINING FEDERAL MATCHING FUNDS, IDEALLY WITH STATE MATCH.***
  - -- Maintain current matching opportunities.
  - -- Support not penalize local governments that have made investment.
  - -- Remove barriers that local governments have in obtaining Fed. match (including preclusion investment already made.)
  - -- Work with Feds to maintain opportunities.
- ***ISSUES RELATED TO STATE FUNDING.***
  - -- Restore full S-CHIP (Healthy Kids) funding without caps, planned in conjunction with school health programs.
  - -- Ideally increase funding particularly when Federal match can be drawn.
  - -- Protect current state funding without passing more costs to the local govt. and people (e.g., eye glass, increased Medicaid match).

LIST OF POTENTIAL STRATEGIES

STRATEGY 1. PROTECT STATE AND FEDERAL FUNDING:

- ***Protect / Maintain State subsidy programs,*** such as
  - Medically Needy: Continued state contribution and no increase in share of cost.
  - Silver Savers (Drugs).
- ***Restore full Healthy Kids funding w/o caps.***
- ***Protect matching concepts,*** such as:
  - Disproportionate Share Hospitals (DSH) and Upper payment limits (UPL)
  - Federally Qualified Health Clinics (FQHC).
  - Community based revenue maximization (passed in last session).

STRATEGY 2. MAXIMIZE REVENUE FROM EXISTING SOURCES:

- ***Evaluate and pursue, if appropriate, Health Insurance Flexibility and Accountability (HIFA) waivers and sub-regional waivers.***
- ***Pick up Medically Needy Share of Costs.***
- ***Better coordination with subsidy programs.***
- ***Maximize revenue from matching concepts (listed above).***

STRATEGY 3. DEVELOP ADDITIONAL AFFORDABLE HEALTH COVERAGE OPTIONS

- ***Build on and leverage investments in local programs*** such as the Hillsborough Health Care.
- ***Build on strengths of individual players and existing assets*** to provide best service while minimizing costs and maximizing revenue.
- ***Work with key groups to remove barriers to new programs*** such as:
  - State regulation (e.g., risk pool constraints, other insurance code changes, and expanded sovereign immunity for care for the low-income.)
  - Perceptions.
- ***Use above to develop additional programs*** such as:
  - Health Flex and other programs for specific geographic or population targets.
  - Programs in which employers, government, and providers share premium (called "3-Share Premium Programs".)
  - Risk pooling arrangements.
  - Combinations of the above and other private / public partnerships.

STRATEGY 4. ADDITIONAL FUNDING

- ***Develop additional State or Federal Government Programs*** such as drugs, grants, and waivers.
- ***Obtain private sector funding*** to be used for seed money not sustaining funds).

STRATEGY 5. COORDINATE KNOWLEDGE OF AND ENROLLMENT IN OPTIONS.

- ***Develop information systems support*** such as county-based, provider-based but coordinated with county, and ties to "211" number.
- ***Enhance role of County Social Services as a source of information.***
- ***Identify and develop other options.***

STRATEGY 6. LINK TO ENHANCED FEDERAL HEALTH CARE POLICY, IF IT OCCURS

Hillsborough County
Florida

Hillsborough County HealthCare Program

OVERVIEW

- The Hillsborough HealthCare Program provides access to health care for low-income residents of Hillsborough County who do not have private insurance, Medicaid or Medicare. Hillsborough HealthCare emphasizes:
  - Primary and preventive care rather than costly emergency room services.
  - Integration of health care, social services and workforce programs.
  - Partnerships with local hospitals and physicians to provide services.
  - Community oversight by the Health Care Advisory Board.
  - Stewardship by working with stakeholders and partnering with providers to contain costs, avoid duplication, and leverage other available sources of funds to address the needs of program participants.
  - Use of competitive contracting to achieve better quality and service, and lower costs.
  - Flexibility and responsiveness to changes in health care delivery.
- Hillsborough HealthCare funds the State required local match for Medicaid payments and the special payment to Tampa General Hospital.
- Hillsborough HealthCare has the support of the Tampa General Hospital, St. Joseph's Hospital, Brandon Hospital, South Bay Hospital, South Florida Baptist Hospital, Tampa Community Health Center, and Suncoast Community Health Clinics as well as the Hillsborough County Medical Association.
- Hillsborough County residents eligible for Hillsborough HealthCare are:
  - At or below 100% of federal poverty level, i.e., $8,860 single person or $15,020 family of three.
  - For some diseases, people between 100% and 150% of federal poverty guideline whose expenses for medical services cause them to have net income below 100% of poverty.
  - Senior citizens receiving Medicare but needing assistance for prescription drugs, dental, and vision services.
- In 2002, Hillsborough HealthCare served over 31,000 residents by funding 105,123 outpatient visits and 15,268 inpatient hospital days and filled 519,035 prescriptions.
- Hillsborough HealthCare is important to local small businesses. Approximately 70% of those served by the Hillsborough HealthCare are either employed or seeking work. The rest are disabled or on a fixed income.

IMPACT:

The investment in Hillsborough HealthCare continues to exceed expectations:

- Decreasing direct health care costs resulting in savings to County taxpayers of over $44M per year.
- Strengthening hospitals and physicians and stabilizing the County's health care industry by reducing unpaid bills.
- Maximizing health care dollars for County residents by:
  - Quicker and increased payments from other insurers and Medicaid ($3M per year).
  - Additional State and Federal reimbursement to hospitals and clinics ($10M per year.).
  - Earlier federal disability assistance for Hillsborough residents ($3M to $5M per year.)
- Improving program participants' ability to maintain employment (Value of over $15M per year.)

The Working Uninsured in Florida

Presentation to House Subcommittee on Health Access & Financing

Ken Thurston
Assistant Deputy Secretary for Medicaid Finance
Agency for Health Care Administration

March 26, 2003
1 pm to 4 pm
Room 214 Capitol
Tallahassee, Florida

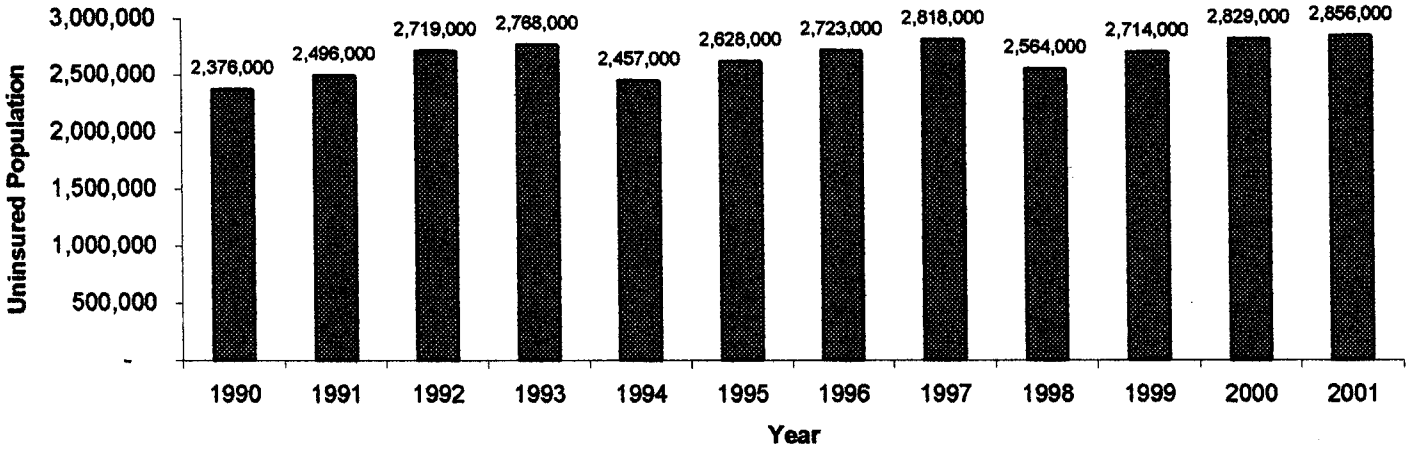
AHCA

FLORIDA MEDICAID

- Florida ranks fourth in the nation in the number of uninsured following California, Texas and New York, according to the March 2002 Current Population Survey. The Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys show that Florida had approximately 2.82 million uninsured non-elderly (under age 65) residents in 2001. This represents 21 percent of Florida's total non-elderly population.

- The uninsured population (includes residents over 65) in Florida has grown 20.2 percent from almost 2.4 million in 1990 to approximately 2.9 million in 2001.

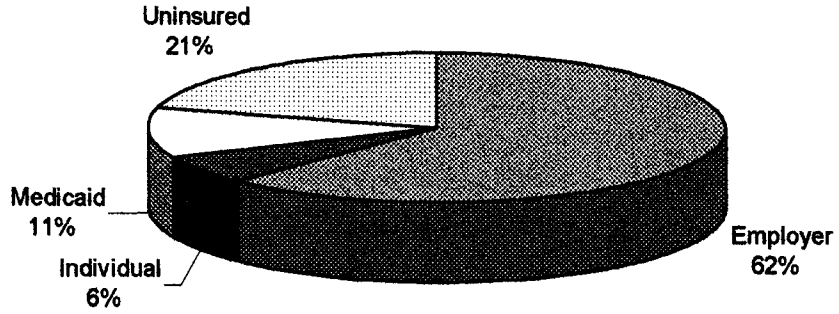
The Uninsured Population in Florida from 1990 to 2001



Source: The U.S. Census Bureau

- In 2001, 62 percent of Florida's non-elderly insured population had employer-sponsored coverage. Only six percent had individual coverage and 11 percent were enrolled in the Medicaid program.

Distribution of Nonelderly 0-64 by Insurance Status, State Data 2000-2001, Florida 2001



Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys

- According to the Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2001 and 2002 Current Population Surveys, 64 percent of Florida's non-elderly uninsured have income less than 200 percent of the federal poverty level ($36,800 for a family of four in 2003).

- In 1999, the Florida Health Insurance Study showed that Florida's uninsured are best described by these characteristics:

  - Income - Nearly half (938,527) of the uninsured earn less than 150 percent of the Federal Poverty Level (FPL), which is $25,575 for a family of four ($27,600 in 2003).

- Employment Status – 50 percent of the uninsured work full or part-time and 62 percent of Floridians gain access to health insurance through their employer. A majority of the working uninsured (89 percent) say they do not have health insurance because their employer does not offer it, or they are not eligible, or they cannot afford it.

- Size of employer – Employers with one to nine employees have the highest rate of uninsurance (24.6 percent), compared to companies with 100 or more employees (4.78 percent).

- Ethnicity – Hispanics make up nearly one-fourth (492,154) of Florida's uninsured population. The rate of uninsurance for Hispanics (28.59 percent) is more than twice the rate of white non-Hispanics (13.2 percent) and almost 50 percent greater than the rate of African Americans (19.6 percent).

- Regional difference – The rates of uninsurance vary widely across the state, ranging from a high of 25.5 percent in District 13 (DeSoto, Glades, Hardee, Hendry, Highlands, Okeechobee, and Monroe Counties) and 24.6 percent in District 17 (Dade County), to a low of 11.8 percent in District 6 (Lake, Osceola and Seminole Counties) and 12.1 percent in District 4 (Duval County).

- According to the 1999 Florida Health Insurance Study (FHIS), among Floridians without health insurance, the most commonly cited reason for lack of coverage was cost. Over 74 percent of uninsured Floridians (1,544,976 individuals) reported an inability to afford the premiums as the main reason for lack of coverage.

- A majority of Floridians under age 65 had employment-based health insurance (62.7 percent). Smaller percentages of Floridians purchased insurance individually (9.0 percent) or were covered under Medicaid and the Florida KidCare program (7.2 percent).

- Employment is no guarantee of health insurance coverage. The uninsurance rate for individuals in households in which at least one person is employed is 16.4 percent, only slightly lower than the 19.4 percent uninsurance rate for individuals in households in which everyone is unemployed.

- The 1999 FHIS showed that about 50 percent of the non-elderly uninsured were either full-time or part-time workers.

- Lack of health insurance is not limited to the lowest income groups in Florida. For example, 26.9 percent of Floridians with family incomes between $20,000-$24,999 are uninsured. Uninsurance rates as high as 9.6 percent exist for Floridians with family incomes in excess of $45,000 per year.

- Floridians with health insurance tend to be in better health than those without health insurance. Among insured Floridians under age 65, about 42.1 percent are reported to be in excellent health. By contrast, only 28.9 percent of uninsured Floridians under age 65 report themselves to be in excellent health.

April 2003

Issue Brief

Covering the Uninsured: Prospects and Problems

Juliette Cubanski, John F. Kennedy School of Government

and

Janet Kline, Health Policy Specialist

For more information, please contact:

Mary Mahon
Public Information Officer
The Commonwealth Fund
One East 75th Street
New York, NY 10021-2692

Tel 212.606.3853
Fax 212.606.3500

E-mail mm@cmwf.org

This *Issue Brief* (#616) is available online only at **www.cmwf.org.**

Other Fund publications can be ordered online or by calling 1.888.777.2744.

To learn about new Fund publications when they appear, visit the Fund's website and register to receive e-mail alerts.

Introduction: The Current Status of Health Insurance Coverage

Increasing the number of Americans with health insurance has been a recurrent focus of federal and state policymaking, and recent trends suggest that the issue continues to warrant legislative attention. The number of people without health insurance coverage in the United States increased in 2001, a reversal of two years of falling rates of uninsurance. According to the Census Bureau, an estimated 14.5 percent of the total population (41.2 million people) lacked health insurance for the entire year in 2001, up from 14.2 percent in 2000—an increase of 1.4 million people.[1] Insurance coverage varies by state of residence, with New Mexico and Texas having the highest average uninsured rates from 1999 to 2001 (23 percent) and Rhode Island and Minnesota the lowest (7.8 percent). Private employment-based insurance remains the primary source of insurance coverage for most Americans, but public programs such as Medicare, Medicaid, and the state Children's Health Insurance Program (CHIP) are an important source of coverage for millions of elderly and disabled individuals and low-income children and adults.

Gaps in private and public coverage leave many Americans without access to health insurance or with only limited coverage. Many workers do not have access to employment-based insurance because they cannot afford it or their employer does not offer it.[2] Coverage in the private, non-group insurance market has been limited because premiums are based on an individual's age and health status, and are substantially more expensive than group plans purchased by employers.[3,4] Medicaid and CHIP cover many low-

This *Issue Brief* was prepared for The Commonwealth Fund/John. F. Kennedy School of Government Bipartisan Congressional Health Policy Conference, January 16–18, 2003.

income Americans, primarily children, but eligibility criteria and covered services for these programs vary across states, resulting in coverage disparities. In addition to gaps that leave millions without insurance, researchers estimate that about one-fifth of insured individuals are underinsured, meaning that they face limits on coverage or substantial financial barriers to receiving treatment if they become ill.[5] Overall, these limitations in public and private coverage are not new. Yet recent trends—such as rising health care costs that fuel growth in health insurance premiums, and higher unemployment rates linked to a weakened economy—could lead to an erosion of the modest coverage improvements seen at the end of the 1990s.

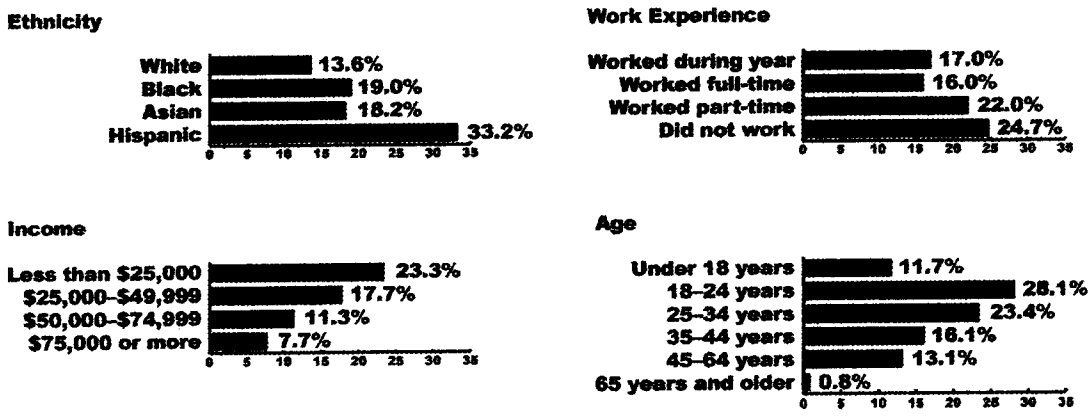
Who Are the Uninsured?

People without insurance cannot easily be categorized. Demographic factors such as age, race, and ethnicity, as well as socioeconomic and employment status, affect health insurance coverage rates. The poor and near-poor have the greatest risk of being uninsured, but the large majority of uninsured also come from working families.[6] Exhibit 1 presents rates of the uninsured in 2001 by selected characteristics.

Trends in Public and Private Coverage

In 2001, almost 200 million people had private health insurance coverage. The vast majority, 176.5 million people, had employer-sponsored coverage. Public programs covered 71.3 million people, including 38 million enrolled in Medicare, 31.6 million covered by Medicaid, 9.5 million with military health care (including care provided by the Veterans Administration), and 2.3 million covered by CHIP. (Coverage estimates by type of plan are not mutually exclusive, since people can have both public and private coverage as well as both Medicare and Medicaid.) Rates of employment-based coverage gradually increased in the mid- to late-1990s, fueled by a good economy, low unemployment, and slower growth in insurance premiums.[7] Enrollment in Medicaid declined following welfare reform in 1996, but state efforts to increase outreach and expand eligibility helped to stabilize Medicaid coverage. The CHIP program, begun in 1997, increased insurance coverage among low-income children. In 1999 and 2000, these coverage trends resulted in a decrease in the total number of uninsured. However, recent trends in coverage and rising health care costs may threaten coverage improvements. As described below, premiums for employer-sponsored coverage are increasing and many employers pass on these rising costs to their employees. States are facing budget constraints that may lead to cuts in eligibility and benefits in public programs such as Medicaid and CHIP. Reflecting these trends, half of insured individuals are worried about not being able to

Exhibit 1. Rates of the Uninsured in 2001 by Selected Characteristics



Source: U.S. Census Bureau, Current Population Survey, 2002 Annual Demographic Supplement.

afford insurance or having benefits cut back in the coming year.[8]

EMPLOYER-SPONSORED INSURANCE TRENDS

The percent of people covered by employer-sponsored insurance decreased in 2001, from 63.6 to 62.6 percent.[9] The declining rate of employer coverage has been accompanied by increasing premiums. Between spring 2001 and spring 2002, monthly premiums for employment-based coverage rose 12.7 percent, significantly faster than wage gains for non-supervisory workers (3.4 percent).[10] Between 2001 and 2002, the worker's share of the overall premium rose by 27 percent for single coverage (an average of $454 per year in total) and 16 percent more for family coverage (an average of $2,084 per year in total).[11] In 2001, the average annual cost to an employer was $3,060 for individual coverage and $7,954 for family coverage.[12]

With a 15 percent average increase in health care premiums projected for 2003, additional increases in employee contributions are likely to occur in the future.[13] A variety of surveys find that employers plan to deal with rising health care costs by increasing employees' share of premiums as well as other cost-sharing measures. An employer survey found that 78 percent of large firms (200 or more workers) plan to increase employee premium contributions in the future, up from 44 percent in 2000.[14] Forty percent of workers in January 2002 reported that they paid more for employer-sponsored coverage in 2001 than in the previous year.[15] Along with increasing the employee contribution for premiums, employers are adopting cost-sharing methods that increase employees' responsibility for decisions about care. These include raising costs for care received out-of-network and copayments for physician and hospital services and prescription drugs. One-third of working adults report higher deductibles or copayments or benefit reductions in 2001 compared with the previous year.[16]

Employers are also evaluating new health plan benefit designs, such as defined contribution and consumer-driven or consumer-directed plans. These insurance arrangements are designed to give workers more choice, flexibility, and control in making health care decisions.[17] In defined contribution plans, employers offer employees a fixed sum to pay for coverage on their own. The employee pays any insurance costs that exceed the employer's contribution. Approximately one-quarter of firms say it is likely they will adopt this approach in the next few years.[18] Consumer-driven plans combine a high-deductible, catastrophic insurance policy (i.e., a major medical plan) with a health reimbursement account (HRA). In this arrangement, a portion of the employer's insurance contribution is placed in a personal health account from which employees can draw to purchase health care services with tax-exempt dollars.[18,19] In June 2002, the Department of Treasury issued a ruling that clarifies that HRAs must be funded solely by the employer and cannot be funded by salary reductions, defines HRAs as group health plans subject to the COBRA continuation requirements, and allows unused balances in HRAs to carry over from one year to the next.[20] These features could increase the appeal of consumer-driven plans. According to a recent survey, about 30 percent of large employers say they will offer a consumer-driven plan by 2003.[21]

Requiring workers to pay higher cost-sharing amounts at the time of use reverses the trend toward lower cost-sharing amounts that accompanied the shift from indemnity insurance to managed care (e.g., a shift from a $100 deductible and 20 percent coinsurance to $10 per visit copayments). Some might argue that such a shift is overdue, since insurance arrangements have tended to insulate consumers from the actual cost of care, which may increase consumption of marginally beneficial services. Some might also argue that this shift is timely because managed care restrictions on use, which accompanied the lower cost-sharing, have been relaxed in recent years—giving rise to the term "managed care lite." Giving employees more control over their health spending through the use of consumer-driven plans could make basic coverage more available and affordable, thereby increasing coverage and relieving employers of increasing cost pressures, but it could also mean that some workers will pay more in costs at the time of use than under their old policies. The

degree to which this ultimately will shift costs to workers will depend to a great extent on the amount the employer contributes as the lump sum and the correlation of high spending across years; i.e., whether high spending in one year is offset by low spending in another, so that in the low-spending year the worker comes out ahead. Requiring workers to pay higher premiums for the same coverage may lead some employees to drop coverage and thus exacerbate the problem of the uninsured.

TRENDS IN PUBLIC COVERAGE: MEDICAID AND CHIP

Among the entire population, the percent covered by government insurance programs rose in 2001, from 24.7 to 25.3 percent. This increase was largely due to an increase in the rate of Medicaid coverage, from 10.6 percent in 2000 to 11.2 percent in 2001.[22] According to the Census Bureau, Medicaid covered 31.6 million people in 2001. Beneficiaries include low-income mothers and children, and elderly and disabled individuals. Congress enacted CHIP as part of the Balanced Budget Act of 1997, providing $20.3 billion in federal funds over five years for states to expand coverage to low-income uninsured children. Enrollment in CHIP grew slowly during the initial years, but as of the end of 2001, total enrollment exceeded three million children. If the downward trend in private employer-sponsored insurance coverage continues beyond 2001, further increases in public program enrollment are likely to occur, absent changes at the state level to limit coverage expansions in order to reduce expenditures.

Prospects for Coverage Expansions

Recent policy debates have emphasized targeted approaches to expanding coverage. Current proposals include increasing enrollment in existing public programs, establishing tax benefits for purchasing health insurance, and expanding coverage through public–private linkages.

PUBLIC PROGRAM CREATION AND EXPANSION

Some policymakers support expanding coverage by building on existing public programs or creating new state-based programs. Proponents of these strategies argue that increasing coverage can be most easily accomplished by expanding eligibility for existing programs. Opponents are concerned about the substitution of public coverage for private coverage, and concerned that such expansions create a larger and less desirable role for government given that the private market is the predominant source of coverage.

Despite these concerns, a number of states have increased enrollment in existing programs by raising income or age eligibility levels for Medicaid and CHIP beyond federal minimums, and opening enrollment to parents of children eligible for these programs. Section 1115 of the Social Security Act provides authority to the secretary of the Department of Health and Human Services (HHS) to waive statutory provisions of the federal law to permit demonstration programs that further Medicaid program goals. As of May 2002, 8.2 million individuals received coverage under Section 1115 waivers, accounting for nearly one-fifth of all Medicaid spending.[23] The Bush administration has also enhanced the flexibility of states to increase coverage in Medicaid and CHIP through the Health Insurance Flexibility and Accountability (HIFA) waiver initiative. Announced in August 2001, HIFA is targeted at populations with incomes below 200 percent of the federal poverty level ($17,720 for an individual in 2002). HIFA allows states to finance coverage expansions by reducing the cost of public coverage in ways not otherwise permitted, such as reducing benefits and increasing cost-sharing for certain groups.[24] Such flexibility is viewed as essential by some states facing budget shortfalls that nevertheless want to implement public program expansions.

Using waiver authority, a few states have taken steps to extend Medicaid or CHIP coverage to low-income parents whose children are eligible for these programs. Research suggests that by covering parents, states can also increase the extent to which uninsured children are enrolled in Medicaid and CHIP.[25,26] In 1999, 11 states and the District of Columbia expanded coverage to parents through either Medicaid or a separate state-funded program.[27] As of October 2002, HHS had approved waivers to cover parents using Medicaid or CHIP funds in six states

(three of which also implemented expansions in 1999).[28,29]

Some states have created programs that target uninsured adults, financed solely through non-federal sources. For example, Pennsylvania's adultBasic program uses $76 million from the state's share of the national tobacco settlement to provide low-cost health insurance for uninsured individuals ages 19 to 64 with low incomes (below 200 percent of the federal poverty level). However, current economic conditions have reduced state tax revenues nationwide and placed competing demands on limited state funds. Thus, the prospects for covering a large number of uninsured people through such state-based programs may be limited in the foreseeable future.

ESTABLISHING TAX BENEFITS FOR HEALTH INSURANCE

Many policymakers favor expanding coverage by creating tax benefits that provide financial incentives for individuals or employers to purchase health insurance. Options include creating a refundable tax credit for all workers, expanding and permanently extending Archer medical savings accounts (MSAs), creating tax credits for small employers, and expanding tax benefits for the self-employed.[30] Proponents of tax benefit approaches argue that they give consumers greater choice and control over their health insurance arrangements, and that they address equity and efficiency problems in current law regarding tax benefits. Opponents argue that these approaches are unlikely to make much difference for people who do not now purchase insurance. A primary concern with the tax credit approach is that depending on the size of the credit, it might not benefit lower-income families who cannot afford to purchase insurance before the subsidy kicks in. Opponents also argue that tax benefit approaches could erode the employment-based system but leave consumers with inadequate and more costly alternatives.

The 107th Congress considered various tax benefit proposals. Proposals were made to expand and permanently extend the authorization for MSAs (set to expire December 31, 2003); to allow self-employed taxpayers to deduct 100 percent of the cost of their insurance beginning in 2002; to allow individuals to deduct 100 percent of their insurance premiums, regardless of whether they itemize; and to authorize a tax credit for small employers (2 to 50 employees). In his Fiscal Year 2003 budget, President Bush allocated $89 billion over 10 years to establish a refundable tax credit for individuals under age 65. Under this approach, people who purchase coverage in the individual market could reduce their federal tax payments by some or all of the amount spent for insurance. A refundable tax credit would enable low-income people to claim the credit even if they owed no taxes.

While most of these proposals were not enacted in the 107th Congress, a tax credit provision was included in trade legislation signed into law in August 2002. The Trade Act of 2002 (P.L. 107-210) provides $12 billion over 10 years for benefits to trade-displaced workers, including a refundable tax credit to cover 65 percent of the cost of health insurance premiums. Uninsured workers who lose their jobs due to increased importation could use the tax credit to purchase insurance through employer-sponsored coverage offered by their former employers (i.e., COBRA coverage), or through state-sponsored insurance purchasing pools and high-risk pools.

EXPANDING COVERAGE THROUGH PUBLIC–PRIVATE LINKAGES

Some policymakers have proposed to expand coverage by using public funds to subsidize the purchase of employer-sponsored insurance. Such an approach could assist low-income people who are offered coverage by their employer, but who cannot afford the employee share of the premium. Proponents of premium assistance, or "buy-in," programs argue that the combination of public funds with employer contributions lessens the strain on both public and private payers and potentially allows funds to cover more people. Building on employer coverage could also help increase coverage by avoiding the stigma associated with enrollment in public programs.

Under current law, states can create premium assistance programs through the Medicaid Health Insurance Premium Payment (HIPP)

program or through CHIP.[31] The cost of the buy-in must be no higher than what the state would have paid to enroll the individual in the public program (the cost-effectiveness test). Establishment of premium assistance programs to date has been limited because states have found the cost-effectiveness test difficult to demonstrate and have had trouble identifying eligible people—those who are enrolled in public programs but who could access employer-sponsored coverage.[32] HIPP enrollment represents only 1 percent of states' total Medicaid program enrollment.[33] To date, seven states have received approval from HHS to develop premium assistance programs using CHIP funds.[34] Despite limited experience with premium assistance, the use of this strategy is likely to increase. The HIFA initiative strongly encourages states to integrate Medicaid and CHIP funds with funds for private health insurance, and relaxes the cost-effectiveness guidelines to facilitate this activity. According to HIFA guidelines, states are not required to adhere to the cost-effectiveness test, but must monitor total costs and ensure that they are not significantly higher than if "buy-in" participants were enrolled in public programs. With this flexibility, states have opportunities to use public funds to subsidize private coverage among the low-income uninsured, while keeping within budget limits.

Potential Barriers to Coverage Expansions

Policymakers face difficult challenges in dealing with the uninsured problem, some of which are due to the design of the insurance system and the nature of public and private coverage. For instance, loss of employment can lead to loss of insurance, but the unemployed are not automatically covered elsewhere.[35] For those who lack a source of employment-based or public coverage, the individual market is the only option. Yet, coverage in this market is unstable and often unobtainable, the result of high prices, medical underwriting practices, and a small risk pool.[36] Also, many uninsured people may be eligible for public programs but do not participate because of enrollment barriers, lack of awareness, or concerns about stigma.

As states implement eligibility expansions through Medicaid and CHIP that target people at higher income levels, policymakers are concerned about minimizing the extent to which public coverage substitutes for existing private coverage. Estimates of the magnitude of this substitution effect, known as "crowd out," vary.[37] A primary concern is that employers might reduce or drop benefits for employees because of the availability of public coverage. In their public program expansions, states have implemented measures to minimize crowd out, such as imposing premiums and establishing waiting periods after losing private coverage. Such policies may prevent crowd out but also may result in more limited enrollment among the uninsured.

Other barriers to expanding coverage stem from more recent trends in health care. For the first time in more than a decade, per capita health care spending rose at a double-digit rate in 2001, increasing by 10 percent.[38] National health spending is expected to grow faster than the gross domestic product (GDP) for the rest of the decade, with the health share of GDP projected to rise from 13.2 percent in 2000 to 17.0 percent by 2011.[39] Thus, even if the uninsured rate does not increase significantly in the near future, health care cost growth makes any measures that would reduce the current uninsured population more expensive.

Conclusion

Incomplete insurance coverage has been a formidable problem for policymakers. Solutions, whether incremental or broader in scope, involve decisions about how to invest public funds. Reaching out to a broad spectrum of uninsured individuals could require a substantial investment of public and private dollars. Conversely, minimizing costs in the current constrained budget environment may mean restricting or limiting the target population for coverage expansions. The factors that currently exist—higher health care costs, increasing insurance premiums and cost-sharing amounts, unemployment growth, and state budget restrictions—suggest that making significant inroads in the uninsured population may be difficult in the foreseeable future.

Exhibit 2. Percent of People Without Health Insurance for the Entire Year by State: 3-Year Average, 1999–2001

State	Percent
United States–Total	14.5
Alabama	13.2
Alaska	17.7
Arizona	18.4
Arkansas	15.0
California	19.2
Colorado	15.1
Connecticut	9.7
Delaware	9.5
District of Columbia	13.6
Florida	17.8
Georgia	15.3
Hawaii	9.7
Idaho	16.5
Illinois	13.6
Indiana	10.8
Iowa	8.0
Kansas	11.4
Kentucky	13.0
Louisiana	19.7
Maine	10.7
Maryland	11.3
Massachusetts	8.7
Michigan	9.9
Minnesota	7.8
Mississippi	15.2
Missouri	8.8
Montana	16.0
Nebraska	9.6
Nevada	17.2
New Hampshire	9.0
New Jersey	12.5
New Mexico	23.2
New York	15.8
North Carolina	14.2
North Dakota	10.9
Ohio	10.8
Oklahoma	17.9
Oregon	13.1
Pennsylvania	8.7
Rhode Island	7.2
South Carolina	13.3
South Dakota	10.4
Tennessee	10.8
Texas	23.0
Utah	13.6
Vermont	9.7
Virginia	11.9
Washington	13.5
West Virginia	14.2
Wisconsin	8.5
Wyoming	15.6

Source: U.S. Census Bureau, Current Population Survey, 2002 Annual Demographic Supplement.

REFERENCES

1 Robert J. Mills. *Health Insurance Coverage: 2001*. Current Population Reports P60–220. U.S. Census Bureau, September 2002.

2 Jeanne M. Lambrew. *How the Slowing U.S. Economy Threatens Employer-Based Health Insurance*. The Commonwealth Fund, November 2001.

3 Kaiser Commission on Medicaid and the Uninsured. *The Uninsured: A Primer*. Henry J. Kaiser Family Foundation, March 2002.

4 Jon Gabel, Kelley Dhont, and Jeremy Pickreign. *Are Tax Credits Alone the Solution to Affordable Health Insurance? Comparing Individual and Group Insurance Costs in 17 U.S. Markets*. The Commonwealth Fund, May 2002.

5 Kaiser Commission on Medicaid and the Uninsured. *Underinsured in America: Is Health Coverage Adequate?* Henry J. Kaiser Family Foundation, July 2002.

6 Kaiser Commission, *The Uninsured: A Primer*, March 2002.

7 John K Iglehart, "Changing Health Insurance Trends," *New England Journal of Medicine* 347 (September 19, 2002): 956–62.

8 Kaiser Commission, *Underinsured in America*, July 2002.

9 Mills, *Health Insurance Coverage: 2001*, September 2002.

10 Iglehart, "Changing Health Insurance Trends," September 19, 2002.

11 Kaiser Family Foundation/Health Research and Educational Trust. *Employer Health Benefits: 2002 Summary of Findings*. Kaiser Family Foundation, September 2002.

12 Ibid.

13 Hewitt Associates. "Health Care Cost Increases Expected to Continue Double-Digit Pace in 2003." Press Release, October 14, 2002. Accessible at http://was.hewitt.com/hewitt/resource/newsroom/pressrel/2002/10-14-02.htm/, accessed October 21, 2002.

14 Kaiser/HRET. *Employer Health Benefits*, September 2002.

15 Jennifer Edwards et al. *The Erosion of Employer-Based Health Coverage and the Threat to Workers' Health Care*. The Commonwealth Fund Issue Brief, August 2002.

16 Ibid.

17 Hewitt Associates. "Health Care Cost Increases," October 14, 2002.

18 Kaiser/HRET. *Employer Health Benefits*, September 2002.

19 Iglehart, "Changing Health Insurance Trends," September 19, 2002.

[20] The ruling specifies that maximum reimbursement amounts deposited by an employer in an employee's HRA in one year would be increased by any unused reimbursement amounts from previous years. The ruling is accessible at http://www.ustreas.gov/press/releases/docs/rev.rul.pdf/, accessed November 22, 2002.

[21] Kathy Kristof, "New Health Care Plans May Not Be a Panacea." *Los Angeles Times*, August 25, 2002.

[22] Mills, *Health Insurance Coverage: 2001*, September 2002.

[23] Jennifer Ryan. *1115 Ways to Waive Medicaid and CHIP Rules*. National Health Policy Forum, Issue Brief No. 777, June 2002.

[24] Jennifer Ryan. *Health Insurance Family Style: Public Approaches to Reaching the Uninsured*. National Health Policy Forum, Issue Brief No. 767, September 24, 2001.

[25] Lisa Dubay and Genevieve Kenney. *Covering Parents Through Medicaid and CHIP: Potential Benefits to Low-Income Parents and Children*. Kaiser Commission on Medicaid and the Uninsured, October 2001.

[26] Institute of Medicine. *Health Insurance Is a Family Matter*. Washington, D.C.: National Academies Press, 2002.

[27] Dubay and Kenney, *Covering Parents*, October 2001.

[28] Ryan, *Health Insurance Family Style*, September 24, 2001.

[29] Centers for Medicare and Medicaid Services. State Children's Health Insurance Program (CHIP) Approved Section 1115 Demonstration Projects, October 7, 2002. Accessible at http://www.cms.gov/CHIP/1115waiv.pdf/, accessed November 4, 2002.

[30] Medical savings accounts are personal savings accounts for unreimbursed medical expenses. They are used to pay for health care not covered by insurance, including deductibles and copayments. The formal name of MSAs is now Archer MSAs. The original MSA legislation (the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191) authorized a limited number of MSAs under a demonstration beginning in 1997.

[31] Ryan, *Health Insurance Family Style*, September 24, 2001.

[32] Leslie Conwell and Ashley Short. *Premium Subsidies for Employer-Sponsored Health Coverage: An Emerging State and Local Strategy to Reach the Uninsured*. Center for Studying Health System Change, Issue Brief No. 47, December 2001.

[33] Ryan, *Health Insurance Family Style*, September 24, 2001.

[34] Ibid.

[35] Lambrew, *How the Slowing U.S. Economy*, November 2001.

[36] Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. *Assessing the Individual Health Insurance Market in the Post-HIPAA Era: A Review of the Literature*, June 2001.

[37] See, for instance, Richard Kronick and Todd Gilmer, "Insuring Low-Income Adults: Does Public Coverage Crowd Out Private?" *Health Affairs* 21 (January/February 2002): 225–37; David Cutler and John Gruber, "Does Public Insurance Crowd-Out Private Insurance?" *Quarterly Journal of Economics* 111 (2): 391–430; Linda Blumberg et al. "Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP," *Journal of Health Economics* 19 (1): 33–60.

[38] Bradley Struck et al., "Tracking Health Care Costs: Growth Accelerates Again in 2001," *Health Affairs* Web Exclusive, September 25, 2002. W299–W310.

[39] Alliance for Health Reform. *Health Care Costs & Health Coverage*, August 2002.

STATE COVERAGE INITIATIVES

An initiative of The Robert Wood Johnson Foundation

search
sitemap
contact us

about SCI | about coverage | research tools | meetings | state reports | publications | coverage matrix | grants

state coverage matrix

State-Only Tax Incentives

States that received a check under this category provide tax relief, either through tax deductions or credits, to an employer or individual who purchases health insurance for themselves, their family, or their employees.

A tax incentive is a credit or a deduction that reduces the cost of purchasing health insurance through a reduction in an individual's or employer's tax burden. Tax credits are amounts subtracted from the income tax liability itself, unlike deductions, which merely reduce adjusted gross income or taxable income. Tax credits may be refundable or non-refundable. Most tax credits are non-refundable, meaning that if a taxpayer's credit exceeds his/her income tax liability, the taxpayer does not receive the difference as a refund. However, with a refundable tax credit, taxpayers whose credits exceed their income tax liabilities receive the difference in the form of a tax refund.

States	State-Only: Tax Incentives			
	Effective Date(s)	Eligible Populations	Deduction or Credit	Amount
California	1/1/1999	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
Colorado	5/25/00	Individual, spouse, dependents	Deduction	100% of premium expenditures, but not >$500
Delaware	1997	Self-employed	Deduction	100% of premium expenditures
Georgia	1/1/99	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
Idaho	4/18/00	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
	1/01/01	Individual, spouse, dependants	Deduction	100% of premium expenditures
Illinois	1/1/96 - 12/31/04	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
Iowa	1/1/96	Individual, spouse, dependents	Deduction	100% of premium expenditures
Kansas	1/1/00 - 12/31/01	Small employers	Credit (refundable)	$35 per eligible employee per month

Maine	1999	Small employers with <5 low-income employees	Credit	Lower of: $125 per employee with dependent coverage; or 20% of dependent premiums
Missouri	1/1/00	Employee (determined by 401(c)1) IRC '86), spouse, dependents	Deduction	100% of premium expenditures
New Jersey	1/1/00	Self-employed, spouse, dependents	Deduction	100% of premium expenditures
New Mexico	4/12/00	Individual, spouse, dependents	Deduction	Surviving spouses/ Married individuals: 25% of medical care expenses including premium expenditures (annual income <$30,000); 15% ($30,000 - $70,000); 10% (>$70,000). *Single individuals/Married individuals filing separate returns:* 25% (<$15,000); 15% ($15,000 - $35,000); 10% (>$35,000). *Heads of Households:* 25% (<$20,000);

				15% ($20,000 - $50,000); 10% (>$50,000).
North Carolina	enacted 5/98, repealed effective 1/1/01	Individual, spouse, dependents	Credit (refundable)	$300 (<225% FPL) $100 (>225% FPL)
Utah	1/1/00	Individual	Deduction	100% of premium expenditures
Wisconsin	1993	Self-employed workers, spouse, dependents	Deduction	100% of premium expenditures
		Employer without employer coverage, spouse dependents	Deduction	50% of premium expenditures

If you have more updated information and would like to see this matrix revised, please contact Madeleine Konig at 202.292.6730, or e-mail SCI@academyhealth.org.

return to top

AcademyHealth
Advancing Research, Policy and Practice

AcademyHealth is the national program office for SCI, an initiative of The Robert Wood Johnson Foundation.
1801 K St NW, Suite 701-L ▶ Washington, DC 20006 ▶ tel: 202-292-6700 ▶ fax: 202-292-6800 ▶ sci@academyhealth.org

NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Comparison of Federal Health Tax Credit Proposals

As of May 29, 2003

Tax Credit Proposal	Tax Exclusion on Employer Financial Contributions	Who gets it?	How do they get it?	Refundable	Amount	Other
JEFFORDS ***S590 (from 107th)*** **Cosponsors: Frist, Breaux, Chafee, Lincoln, Carper, Snowe, Toricelli, Hagel, Dayton**	Not impacted	Individuals with an annual adjusted gross income less than $35,000 or families with an annual adjusted gross income less than $55,000; Has a $10,000 income phase-out.	Can be obtained as a part of income tax filing process or through a private sector advanced payment option administered by an insurance company or HMO.	Yes	$1,000 per individual; $2,500 family maximum. $400 per individual in an employer sponsored plan. $1000 per family in an employer sponsored plan.	Has a provision to allow CHIP funds to be combined with tax credit dollars for certain low-income individuals and families.
GRANGER ***HR 1236*** **Cosponsors: Beauprez, Bonilla, Boozman, Bradley, Brown-Waite, Burgess, Arthur Davis, Danny Davis, Diaz-Balart, Feeney, Fletcher, Goode, Hostettler, Nancy Johnson, Manzullo, Meeks, Millender-McDonald, Musgrave, Northrup, Norton, Norwood, Otter,**	Not impacted	Individuals with an annual adjusted gross income less than $65,000 or families with an annual adjusted gross income less than $105,000, on a sliding scale basis.	Can be obtained as a part of income tax filing process or through a private sector advanced payment option administered by an insurance company or HMO or employer.	Yes	$1,000 per individual. $500 for children (maximum of two children) for the purchase of coverage through an individual health insurance plan. 25% of the credit amount is available for purchase in an employer sponsored plan.	Allows an additional credit of 50% of premiums not covered by the credit which is especially useful for older individuals or individuals who reside in high premium areas. This additional credit is only available for individual

Tax Credit Proposal	Tax Exclusion on Employer Financial Contributions	Who gets it?	How do they get it?	Refundable	Amount	Other
Owens, Rogers, Paul Ryan, Simpson, Terry, Towns, Watson, Wynn						market plans.
SUSAN COLLINS ***S100*** **Landrieu**	Not impacted	Individuals who earn up to $30,000 and families earning up to $60,000	Through a tax return at the end of the year or can be advanced to and administered by the insurance company	Yes	Up to $1,000 per individual and up to $3,000 for families	Also includes a tax credit to small employers, expands Medicaid, increases outreach to rural and underserved areas, and expands access to long term care insurance.
JEFF BINGAMAN ***S1030*** **No cosponsors at this time**	Not impacted	Individuals up to 200% of the poverty level.	Can be obtained as a part of income tax filing process or through a private sector advanced payment option administered by an insurance company or HMO or employer or purchasing pool.	Yes	Percentage credit similar to rules for FEHBP	Also expands Medicaid with full federal funding to individuals up to 100% of poverty, provides new access to state purchasing pools and gives individuals and businesses access to these pools.
MARK KENNEDY ***HR583*** **Akin, Baker, Ballenger, Barton, Beauprez, Bilirakis, Bonilla,**	Not impacted	Everyone who buys insurance and is not eligible for an employer based plan, except	Through a tax return at the end of the year or can be advanced to and administered by the insurance company.	Yes	$1,000 per individual; $3,000 family maximum.	Requires states to establish High Risk Pools for uninsurable individuals.

Tax Credit Proposal	Tax Exclusion on Employer Financial Contributions	Who gets it?	How do they get it?	Refundable	Amount	Other
Bono, Boyd, Bradley, Brown, Brown-Waite, Burgess, Burton, Camp, Cannon, Cantor, Capito, Carter, Chocola, Cole, Cramer, Crowley, Artur Davis, Danny Davis, Jo Ann Davis, Diaz-Balart, Dooley, Doolittle, Drier, Emmanuel, English, Forbes,, Ford, Fossella, Gilchrest, Gillmor, Goode, Goodlatte, Graves, Green, Greenwood, Gutknecht, Hart, Herer, Hoeffel, Hostelller, Hyde, Timothy Johnson, Walter Jones, King, Kingston, Kirk, Kline, LaTourette, Lipinski, Frank Lucas, Ken Lucas, Manzullo, McHugh, McInnis, Miller, Musgrave, Myrick, Ney, Northup, Norwood, Osborne, Owens, Pearce, Pence, Colin Peterson, John Peterson, Pitts, Platts, Putnam, Ramstad, Rehberg, Mike Rogers, Mike D. Rogers, Rohrabacher, Ros-		Medicare eligibles, those in prison, recipients of VA or Indian health benefits. Not means tested.				Includes a five-year employer maintenance of effort provision. Provides for the establishment of IMAs.

Tax Credit Proposal	Tax Exclusion on Employer Financial Contributions	Who gets it?	How do they get it?	Refundable	Amount	Other
Lehtinen, Ross, Paul Ryan, Jim Ryun, Scott, Shadegg, Shimkus, Simpson, Chris Smith, Nick Smith, Sullivan, Tancredo, Terry, Thompson, Tiahrt, Tiberi, Towns, Walden, Weldon, Whitfield, Wicker SANTORUM S683 (from 107th) Cosponsors: Zell Miller, Torricelli, Bob Smith, Allard, Inhofe, Shelby						

NOTE: The information presented in this table is the exclusive property of the National Association of Health Underwriters (NAHU), and was prepared as an informational resource to the members and staff of the United States congress, the Executive Branch, and NAHU members. It is not to be duplicated, copied, or taken out of context. Any omission or incorrect data in representing the various House and Senate bills is unintentional. Please refer to the original bills for clarification. For questions contact NAHU's Vice-President of Government Affairs, Janet Trautwein at (703) 276-3806, jtrautwein@nahu.org.

Guidelines for States Interested in Applying for a HIFA Demonstration

I. Applying for a HIFA demonstration

This guidance outlines the program and budget parameters for proposals to qualify as a HIFA demonstration. For consideration as a HIFA demonstration, a proposal must be statewide and must seek to develop coordinated private and public health insurance coverage options to low income uninsured. The most comprehensive approaches will include both Medicaid and SCHIP waiver requests, but proposals that utilize only Medicaid or only SCHIP funds may be considered as part of the HIFA demonstration initiative if the demonstration goals are consistent with those outlined in this guidance. Demonstrations that differ from the HIFA model will continue to be reviewed by the Administration on a proposal-by-proposal basis.

State proposals that meet the parameters outlined in this guidance, including complete submission of accurate data required to develop a demonstration budget agreement, will receive efficient and priority review. The State proposal must contain all of the required information before the proposal will be considered officially submitted to HHS. HIFA demonstration proposals should be submitted via the application template (PDF 222KB) developed by HHS. The application template (PDF 222KB) outlines the information that must accompany a HIFA proposal.

In addition to the application template, the state should complete the Medicaid budget neutrality template and/or SCHIP allotment neutrality template, depending upon the financing structure of the proposed demonstration.

Note: *The neutrality templates are in CSV (comma delimited) format and also zipped to minimize download time. After downloading, you should unzip with the appropriate software and then open the files using a spreadsheet program.*

II. Eligibility

Eligibility definitions used in this guidance

This guidance will refer to possible populations that may be covered under a HIFA demonstration as follows:

1. **Mandatory Populations:** Refers to those eligibility groups that a State must cover in its Medicaid State Plan, as specified in Section 1902(a)(10) and described at 42 CFR Part 435, Subpart B. For example, States currently must cover children under age 6 and

pregnant women up to 133 percent of poverty.

2. **Optional Populations:** Refers to eligibility groups that can be covered under a Medicaid or SCHIP State Plan, i.e., those that do not require a section 1115 demonstration to receive coverage and who have incomes above the mandatory population poverty levels. Groups are considered optional if they can be included in the State Plan, regardless of whether they are included. The Medicaid optional groups are described at 42 CFR Part 435, Subpart C. Examples include children covered in Medicaid above the mandatory levels, children covered under SCHIP, and parents covered under Medicaid. For purposes of the HIFA demonstrations, Section 1902(r)(2) and Section 1931 expansions constitute optional populations.
3. **Expansion Populations:** Refers to any individuals who cannot be covered in an eligibility group under Title XIX or Title XXI and who can only be covered under Medicaid or SCHIP through the section 1115 waiver authority. Examples include childless non-disabled adults under Medicaid.

Eligibility parameters under a HIFA demonstration project

Under a HIFA demonstration, States will retain current law flexibility to decide their Medicaid and SCHIP coverage levels. States must continue to cover mandatory populations as specified in Title XIX. States that receive SCHIP funding must maintain their Medicaid eligibility levels for children as of June 1997.

The HIFA demonstration initiative does not limit the upper eligibility level; however, the focus of the HIFA initiative addresses uninsurance among individuals with incomes below 200 percent of the FPL. Within the program and budget parameters outlined in this guidance, we encourage states to think creatively about how Medicaid and SCHIP funding can be used to maintain and encourage coverage in the group health plan market. States requesting the use of waiver authority to extend Medicaid or SCHIP eligibility above 200 percent of the FPL will be expected to demonstrate in their waiver submission that: 1) Focusing resources on populations below 200 percent of the FPL is unnecessary because the State already has high coverage rates in this income range; and 2) covering individuals above 200 percent of the FPL under the demonstration will not induce individuals with private health insurance coverage to drop their current coverage.

III. Benefit Package

States will be required to continue to provide the benefit package specified in their Medicaid State plan to mandatory populations. However, States will have additional flexibility under the HIFA initiative to modify their current benefit packages for optional Medicaid and SCHIP populations. For optional Medicaid populations and SCHIP-eligible children that may be covered under the state plan, the State may provide one of the benefit packages identified in Title XXI. These packages include:

- The benefit package for the health insurance plan that is offered by an HMO and has the largest commercial, non-Medicaid enrollment in the State;
- The standard Blue Cross/Blue Shield preferred provider option service benefit plan that is described in, and offered to Federal employees under 5 U.S.C. 8903(1). (Federal Employees Health Benefit Plan (FEHBP));
- A health benefits coverage plan that is offered and generally available to State employees;
- A benefit package that is actuarially equivalent to one of those listed above; or,

- Secretary approved coverage.

Benefit packages for optional populations should include these basic services: inpatient and outpatient hospital services, physicians surgical and medical services, laboratory and x-ray services, well-baby and well-child care, including age appropriate immunizations.

States will have even greater flexibility in designing the benefit package for expansion populations. The benefit package for this population must include a basic primary care package, which means health care services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician. With this definition states have flexibility to tailor the individual definition to adapt to the demonstration intervention and may establish limits on the types of providers and the types of services. Benefit packages that differ from the State Plan or one of the above will be subject to the Secretary's approval and must be comprehensive enough to be consistent with the HIFA goal of increasing the number of individuals in the State with health insurance coverage. The additional costs of expansion populations must not increase Federal expenditures in excess of a State's waiver budget neutrality agreement (as outlined under "Financing and Budget Neutrality" below).

IV. Cost Sharing

Cost sharing for mandatory populations will continue to be limited to nominal amounts as defined in regulation. States will be provided flexibility to define cost sharing for optional Medicaid populations and expansion populations. However, cost sharing for optional children eligible for Medicaid or SCHIP should not exceed 5 percent of the family's income. In cases where an entire family is covered, this guideline does not need to apply to cost sharing not attributable to individual family members, such as a family premium. However, the 5 percent limit should apply to cost sharing attributable to children, such as copayments for children's visits to physicians.

V. Emphasis on Private Health Insurance Coverage

Under the HIFA demonstration initiative, the Administration strongly encourages State proposals that would further integrate, or at a minimum coordinate, Medicaid and SCHIP funding with private health insurance options. Private health insurance options include both group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Service Act. The Secretary will permit flexibility in the State's definition of benefit package and cost-sharing for optional and expansion populations in support of increased use of private group health plan premium assistance programs. States should continue to ensure that mandatory Medicaid eligibility populations continue to receive the benefit package specified in its Medicaid State plan and are subject to only nominal cost sharing.

States will not be required to meet a specific cost effectiveness test for premium assistance programs as part of comprehensive approaches that promise to decrease the number of uninsured under 200 percent of the FPL. States should monitor that aggregate costs for those enrolled in premium assistance programs are not significantly higher than costs would be if under a direct coverage program, for the propose of controlling both State and Federal costs under the demonstration. All premium assistance benefit costs will be subject to the demonstration budget limits outlined under "Financing and Budget Neutrality" below.

Medicaid and SCHIP expenditures are not intended to supplant employer contributions to their

employees' health coverage. Moreover, Medicaid and SCHIP coverage is not intended to replace insurance coverage that individuals currently purchase. States should closely monitor changes in employer contribution levels and be prepared to make modifications in their programs if providing premium assistance proves to negatively affect employer coverage. For example, a State might make sure that employers participating in the State's premium assistance program maintain the same contribution level for its employees regardless of their eligibility for the program. In exchange for flexibility in designing its premium assistance programs, States will be expected to closely evaluate these elements as described further in the "Tracking the Uninsured Rate and Evaluating the HIFA Waiver Approach" section. States are also encouraged to make accurate information on any enacted federal health insurance tax credits available to anyone applying for Medicaid or SCHIP benefits.

VI. Waiver Approval Period

As with other section 1115 demonstrations, HIFA projects will be approved for an initial five-year period from the date of project implementation. The Administration is committed to work with States and legislators to seek permanent statutory changes incorporating successful coverage approaches demonstrated under the HIFA waiver initiative. State requests for extensions of previously approved statewide waivers will be reviewed per section 4757 of the Balanced Budget Act of 1997 and section 703 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. These states will be asked to begin tracking and reporting the data requested under Section VIII of this waiver guidance if the State is not tracking the information at this time.

VII. Financing and Budget Neutrality

The HIFA demonstration project is a venue for States to explore methods to use current level Medicaid and SCHIP resources to increase health insurance options within their state. Section 1115 waivers are required to be budget neutral to Medicaid to ensure that demonstration projects do not increase federal funding over what would have been spent under current law program requirements. Each state demonstration will operate under a budget neutrality agreement that will limit federal financial payments over the life of the demonstration and that is negotiated prior to approval of the waiver. Below are guidelines under which the Administration will negotiate budget neutrality agreements with States. HHS has developed a sample worksheet for States to use to facilitate the review of their waiver proposals. The information is intended to facilitate State and Federal officials reaching agreement on budget neutrality in the briefest possible period of time.

Expenditures subject to a federal waiver limit

HIFA demonstration budget agreements will place a limit on all expenditures affected by the proposed demonstration. This agreement may include several of a State's Medicaid and SCHIP resources, including:

- **Medicaid Medical Assistance Payments:** Demonstration expenditures limited by the budget ceiling will include all medical assistance payments for those Medicaid eligibility groups affected by waiver provisions in a State's proposal. The technical approach to establishing a limit on federal medical assistance payments is described below and CMS staff is available to lend technical assistance.
- **Medicaid Disproportionate Share Payments:** States may reallocate State and Federal share of DSH funding to increase health insurance options. State will receive the authority to access Federal payments for expenditures which would not have otherwise be matchable. However, in order to maintain budget neutrality, HIFA waivers will not permit

States to access more DSH funding than is possible under their current law DSH funding formulas. The lower of the statewide DSH allotment or current level DSH expenditures will be a component of the budget ceiling if the State is reallocating funds which would otherwise become DSH payment. The hospital-specific DSH limits under OBRA 1993 will continue to apply.

- **SCHIP allotments:** Any State submitting a proposal that includes Title XXI funds may include the full amount of their allotment, but may not including future redistributed funds since these funds are not available to a State on an ongoing basis. All proposals should be allotment neutral, i.e., should not project spending above the allocated funding level for SCHIP-eligible populations provided by statute. States may enroll individuals in both Medicaid and SCHIP programs under a HIFA demonstration. However, the HIFA demonstration will not result in changes to the rate for Federal matching payments for program expenditures. If individuals are enrolled in both Medicaid and SCHIP programs under a HIFA demonstration, the Medicaid match rate will apply to FFP for Medicaid eligibles, and the SCHIP enhanced match rate will apply to FFP for SCHIP eligibles.

Calculation of federal limit on Medicaid medical assistance payments

CMS will work with states on the following calculations to ensure budget neutrality of proposed waiver projects. Actual Federal expenditures under the waiver demonstration will be limited by a budget ceiling calculated from the following components:

1. **Base year per capita estimate:** A base year for purposes of calculating the budget neutrality ceiling will be established. The base year will be a recent 12-month period of experience prior to approval of the waiver. Base year expenditure and enrollment data (calculated in member months) will be used to calculate base year per capita costs for each mandatory and optional eligibility group included under a HIFA waiver proposal. The state will be required to finalize all base year expenditure and enrollment data with CMS no later than one year from waiver approval. No amendments will be made to the per capita calculations for State Plan amendments submitted after approval of a HIFA demonstration.
   Exclusion of impermissible base year expenditures: Base year expenditure and per capita amounts, and trended per capita amounts will be adjusted to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memorandums or regulation. CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

2. **Growth rate calculation:** An annual trend rate will be applied to the per capita calculation in #1 based on:
   (1) Medical Care Consumer Price Index, published by the Bureau of Labor Statistics. This option does not account for State-specific variation in projected program growth, but permits the State to avoid the trend rate negotiations over historical expenditure data. The Medical Care Consumer Price Index will only be offered to States proposing statewide waivers under the HIFA demonstration project.

   OR

(2) State Medicaid-specific growth rate. States should submit five years of historical data for assessment by CMS, with quantified explanations of trend anomalies. Impermissible provider payments should be removed from the expenditure history. The application template developed by HHS includes a sample worksheet for submission of historical data. This option permits States to negotiate with CMS a trend rate indicative of what the state specific spending would have been in absence of an approved HIFA waiver. CMS will maintain a policy that trend rates are the lower of State specific history or the President's Budget Medicaid baseline for the eligibility groups covered by a State's proposal. This option will lengthen the review time for a State's HIFA proposal because of the data generation and assessment required to establish a state specific trend factor.

3. **Calculation of federal waiver annual expenditure ceiling:** Annual expenditure limits for each eligibility group are the product of the number of current law eligibles (calculated in member months) reported by the State multiplied by the appropriate annual per capita expenditure estimate (product of base year per capita in #1 above and trend rate in #2). Expansion populations are not included in these calculations. States are at risk for the Federal cost of expenditures for expansion populations under their budget neutrality agreement. As part of the waiver partnership, States will agree to work with CMS to complete annual budget neutrality assessments based on actual State demonstration expenditures within three months of the end of each demonstration year.

General budget neutrality principles:

- **Use of prior year "savings":** While annual assessments of State spending will be conducted, budget neutrality will be assessed over the life of the initial five-year demonstration. For each subsequent three-year extension approved by HHS, budget neutrality will be assessed over the most recent five-year window. For example, budget neutrality for a three-year extension of a waiver that has operated for its initial five year demonstration will be calculated based on year 4 and 5 of the initial demonstration, plus the three years of the extension.
- **Amendments to the budget neutrality agreement:** For the most part, amendments to the budget neutrality agreement will not be permitted. Specifically, the base year per capita amount will not be adjusted to reflect changes to a State's Medicaid plan in areas such as benefit package and provider payments. States' requests to amend their HIFA budget neutrality agreements to include additional optional populations will be considered by CMS if these populations are provided coverage statewide and receive one of the benefit packages described in Section III for optional populations.

Other General Financing Principles

· State proposals that include waiver requests of Medicaid provider payment rules (such as the inpatient upper payment limit requirements at 45 CFR 447.272) will be closely scrutinized and may result in a lengthened waiver review period.

· Premium collections and other offsets will be used to reduce overall program expenditures before the State claims Federal match. Federal financial payments will not be provided for expenditures financed by collections in the form of pharmacy rebates, third party liability, or premium and cost sharing contributions made by or on behalf of program participants.

· As the purpose of the HIFA waiver is to create new coverage options, states will not be permitted to receive additional Federal match for previously state-only heath service programs under a waiver. Federal financial participation will not be claimed for any existing State-funded program. If the State is seeking to expand participation or benefits in a State-funded program, a maintenance of effort requirement will apply. Waiver proposals that request Federal match for direct services rather than health insurance coverage will be closely scrutinized and are not likely to be approved.

VIII. Tracking the Uninsured Rate and Evaluating the HIFA Waiver Approach

The purpose of HIFA demonstrations is to reduce the number of uninsured individuals, particularly with incomes under 200 percent of the FPL (in certain limited circumstances described above, coverage can be extended to individuals with incomes above 200 percent of the FPL). States should present detailed coverage goals in their submission. The HIFA demonstration data reporting requirements outlined below are intended to build upon the performance and data systems that States already have in place for their current law SCHIP programs.

Required Proposal Elements

States should provide:

(a) An assessment of the current uninsured rates within the state for all groups under 200 percent of the FPL and any other group the state is proposing to cover under the HIFA demonstration. States should also provide any available projections of future uninsured rates.

(b) An assessment of insurance coverage levels in the state categorized by coverage sources, including Medicaid and SCHIP direct coverage, Medicaid and SCHIP premium assistance programs, and those covered through employer sponsored insurance, other group health plans including COBRA coverage, and individual market coverage.

(c) The state's coverage goals. For example, as a result of the HIFA demonstration, the state expects the uninsured rate for families to decrease by 5 percent. Moreover, states should articulate their comprehensive strategy to address the uninsured.

(d) A plan to track changes in the uninsured rate and trends in sources of insurance as listed above. States should monitor employer contribution levels and whether there are unintended consequences of the demonstration, such as major decreases in employer contribution levels or high levels of substitution of private coverage. This can be done using CPS or a state survey, provided that the survey instrument is consistent throughout the life of the demonstration.

(e) As part of their proposal, States are encouraged to submit a list of performance measures they plan to use to evaluate the effectiveness of their HIFA demonstration. Performance measures should address issues like access to care, quality of care, and outcomes.

State Progress Reports

Within 6 months of the end of each demonstration year, states should submit a progress report on their demonstration addressing:

(a) Uninsured Rates- whether the state's HIFA demonstration has resulted in a decrease in the rates of uninsurance,

(b) Effectiveness of HIFA Approach- What aspects of the HIFA demonstration appear to be more or less effective; e.g., were beneficiaries enrolled in private insurance more or less likely to remain insured than those receiving direct coverage.

(c) Impact on Employer Coverage- Assessment of whether the approach is displacing employer contribution levels or beneficiary enrollment in private group health plan coverage.

(d) Other Contributing Factors- The extent to which other factors (e.g., changes in the economy) resulted in a change the uninsured rate.

(e) Progress on any other performance measures the state has identified for its demonstration.

Independent Evaluation

In addition to the state progress reports, an independent evaluation on the HIFA demonstrations will be conducted. CMS will procure an independent evaluation contractor (or contractors) to conduct evaluations on the HIFA demonstrations. The contractor(s) will compare states' progress with their stated goals, make comparisons across states, evaluate differences in outcomes according to the different approaches used by states, and generally evaluate the effectiveness of the HIFA demonstrations in reducing overall uninsurance rates.

Inquiries:
Send inquiries to the HIFA information clearinghouse at: HIFA@cms.hhs.gov

Note: This page includes links to specialized data and multimedia files. Viewing these files requires the use of a third-party plug-in or viewer. For more information or to test whether your computer can read these files, visit our File Formats and Plug-Ins page.

Return to previous page

Center for Medicare & Medicaid Services

Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative

Introduction

The Administration invites States to participate in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, a newly developed Medicaid and State Children's Health Insurance Program (SCHIP) section 1115 waiver approach. The primary goal of the HIFA demonstration initiative is to encourage new comprehensive state approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. The Administration puts a particular emphasis on broad statewide approaches that maximize private health insurance coverage options and target Medicaid and SCHIP resources to populations with income below 200 percent of the Federal poverty level (FPL).

This guidance provides the general parameters for HIFA demonstration projects. Within these parameters, States will be provided flexibility to determine their own approaches in exchange for demonstrating increased health insurance coverage in the State. States will be asked to systematically track the impact of their HIFA demonstration on the uninsured rate for individuals with incomes under 200 percent of the FPL.

Through the HIFA demonstration project, we hope to work with States to:

- Encourage innovation to improve how Medicaid and SCHIP funds are used to increase health insurance coverage for low-income individuals.
- Give States the programmatic flexibility required to support approaches that increase private health insurance coverage options.
- Simplify the waiver application process by providing clear guidance and data templates.
- Increase accountability in the State and federal partnership by ensuring that Medicaid and SCHIP funds are effectively being used to increase health insurance coverage, including substantially more private health insurance coverage options.
- Give priority review to State proposals that meet the general guidelines of the HIFA demonstration project outlined below.

Guidelines for States Interested in Applying for a HIFA Demonstration

Inquiries:
Send inquiries to the HIFA information clearinghouse at: HIFA@cms.hhs.gov

Return to previous page

Premium Subsidies for Employer-Sponsored Health Coverage

An Emerging State and Local Strategy to Reach the Uninsured

Issue Brief No. 47

December 2001

Leslie Jackson Conwell, Ashley C. Short

With nearly 75 percent of the uninsured living in households with at least one full-time worker, there has been renewed policy interest in strategies to expand coverage by subsidizing employer-sponsored insurance. Six of the 12 nationally representative communities that the Center for Studying Health System Change (HSC) tracks have premium assistance, or subsidy, programs planned or underway. Policy makers are enthusiastic about the potential to expand coverage through these programs, but enrollment has been modest to date. This Issue Brief examines operational challenges facing subsidy programs, such as how to structure a benefits package within budgetary and regulatory constraints and how to attract employers and employees without displacing existing private contributions to premiums. It also discusses the trade-offs policy makers may face to resolve these challenges in the context of rising premiums and a slowing economy.

Renewed Interest in Premium Assistance Programs

State and local governments are beginning to develop subsidy programs to make employer-sponsored health insurance more affordable for the working uninsured.[1] HSC identified such efforts in half of its 12 study sites during its 2000-01 site visits (see Table 1). Some of these programs, such as New Jersey's Premium Support Program, provide subsidies to employees, while others, such as the Massachusetts Insurance Partnership, subsidize employers.

New York state has taken a different approach to help keep the cost of premiums down by subsidizing health plans for some of the program's high-cost claims. Many programs, including New York's, specifically target small firms where access to coverage is more limited.

Recent legislative and regulatory changes have bolstered interest in premium subsidies. The State Children's Health Insurance Program (SCHIP) allows states to use SCHIP funds to subsidize eligible families' employer-offered health insurance. In addition, the Bush Administration's Health Insurance

Flexibility and Accountability (HIFA) initiative, a federal demonstration program, encourages states to explore ways to use Medicaid and SCHIP funds to subsidize private health insurance for low-income people.

Premium subsidies for employer-sponsored insurance are attractive to policy makers for several reasons:

- Combining public subsidies with employer contributions lessens the strain on public coffers and potentially allows available funds to cover more people.
- Because the subsidies build on employer-based coverage-the primary source of coverage for non-elderly adults-they help to mitigate the stigma often associated with public programs.
- The programs often allow children and parents to have the same source of coverage, which studies indicate increases the likelihood that families will access needed medical services.

Nevertheless, premium subsidies have had limited success. In 1990, Medicaid created the Health Insurance Premium Payment program, which required states to subsidize the cost of employer-sponsored insurance for eligible adults when this arrangement would be more cost-effective than enrolling them in Medicaid. But states had trouble identifying eligible people and gaining cooperation from employees and employers.[2] Ultimately, the program was made optional, and its use is minimal. Foundation-funded premium subsidy initiatives were implemented in the late 1980s, but these failed to attract participants because of a lack of public awareness and employers' fears that they would be unable to maintain benefits after the grants ended.[3]

Back to Top

Operational Challenges

Subsidy programs at HSC's sites developed as part of state or local efforts to expand coverage, such as state Medicaid expansions, SCHIP programs or local programs to care for the uninsured. Since few other public insurance initiatives require interaction with employer-sponsored plans, program officials have faced a steep learning curve in integrating the two. Regulatory requirements have been particularly complex. In addition, program developers have struggled to design subsidies that are large enough to attract enrollees, while not substituting for existing employer contributions to health insurance premiums.

Designing the Benefits Package. The types of funds used to finance premium subsidy programs dictate how much flexibility policy makers have in program design because of associated regulatory requirements. The premium subsidy programs observed in HSC's study sites fall into three major categories:

- federal and state partnerships financed with Medicaid or SCHIP funds (e.g., programs in Massachusetts and New Jersey);
- state programs using state funds exclusively (e.g., programs in New York and Washington); and
- local programs using a combination of county funds and federal and state resources (e.g., proposed programs in Indianapolis and Lansing, Mich.).

Programs structured as federal/state partnerships have larger budgets, but a variety of requirements regarding the benefits package and enrollee cost sharing constrain design flexibility and tend to make coverage more expensive. For example, programs using SCHIP funds must ensure the benefits package is comparable to the relatively generous SCHIP package or some other designated benchmark, and employer-sponsored plans often do not meet this standard. Indeed, Massachusetts found very few applicants had access to a SCHIP-qualified benefits package through employers.

Some programs have addressed this problem by providing wraparound benefits packages to supplement employer-sponsored plans. For instance, if the benchmark plan covers 60 mental health visits annually, but an employer's plan only covers 20, the premium subsidy program might cover the remaining 40 visits. However, this can be cumbersome administratively, especially given the variety of benefits packages in the employer-sponsored health insurance market. New SCHIP regulations that allow states more flexibility to determine whether a benefits package is adequate could mitigate this problem. Medicaid and SCHIP regulations also place limits on costs borne by enrollees to ensure that care is affordable.

Medicaid-funded programs cannot charge certain enrollees for any portion of the premium, and copayments cannot exceed those in the state's Medicaid program. Similarly, SCHIP funding requires that families do not spend more than 5 percent of their income on children's health care expenditures, including copayments; states may set even lower caps. Complying with these requirements has challenged programs to find mechanisms to track individuals' health care spending and income to make sure that patients are not billed inappropriately.

Locally and state-funded programs are able to avoid many of these federal constraints, but they tend to have smaller budgets. These programs generally have kept costs down by offering a less generous benefits package than other public programs or employer-sponsored plans. In theory, this also allows employers and employees to purchase less expensive coverage than they typically can find in the private market. For example, Lansing's program is considering excluding coverage for maternity care because most women enrollees would be eligible for Medicaid once they become pregnant. Other programs have made difficult cost-benefit tradeoffs For example, New York's program received an exemption to eliminate some state-mandated benefits, such as chiropractic care and behavioral health, in an effort to keep down the cost of the benefits package, although this has not always proved effective.

Avoiding Substitution. While program officials want to encourage businesses to offer insurance and employees to accept it, they do not want premium subsidy programs to displace existing private contributions to health insurance coverage. Like other public programs, some premium subsidy programs address this problem with look-back periods that exclude individuals who have had private insurance during a specified period in the past. Some programs also have look-back periods for employers to discourage them from dropping existing coverage to gain access to the public program. To participate in Healthy New York, for example, employers cannot have offered insurance during the previous 12 months.

Programs subsidizing employees' share of premiums often require employers to make a minimum premium contribution to ensure they maintain some financial responsibility for health care coverage. For example, states receiving federal funds must set minimum contribution levels for employers; currently these range from 40 percent to 60 percent. One drawback to this approach is that employers may decrease their existing contributions to the required minimum, which would increase the burden on public funds and could make insurance less affordable to other low-income employees who are ineligible for premium subsidies.

Table 1
Subsidizing Employer-Sponsored Insurance in Three Communities

Program Type	FEDERAL/STATE PARTNERSHIP		STATE-ONLY PROGRAM	COUNTY/LOCAL PROGRAM
Program Name, Location, Start Date	Premium Assistance	Insurance Partnership	Healthy New York*, N.Y., 2001	Small Employer Subsidized Health Program, Lansing, Mich., expected 2001
Current Enrollment	12,000 lives	4,000 business	More than 1,000 lives	Not applicable
Structure	Provides full or partial subsidies to employees for employer-sponsored insurance	Provides fixed-dollar subsidies to small employers for their share of premium	Indirect subsidy; stop-loss pools reimburse HMOs for 90 percent of costs for claims between $30,000 and $100,000	Program, employer and employee each contribute roughly one-third of the premium for employer-sponsored insurance
Eligibility	Children and their families with income between 150 and 200 percent of the federal poverty level (FPL); adults with income up to 200 percent of FPL who work for participating small businesses	Small businesses that employ low-income workers and contribute at least 50 percent to health care premium	Small businesses that have not offered group coverage for 12 months; one-third of employees must earn less than $30,000 a year; employer contributes at least 50 percent of the health care premium	Small businesses that do not offer health insurance and pay a median wage of $10 per hour

*Individuals, including sole proprietors, also are eligible for Healthy New York.

Back to Top

If You Build It, Will They Come?

After grappling with design decisions, developers of premium subsidy programs have confronted the

next problem: modest enrollment. Some of this can be attributed to the newness of the programs. For example, New York's program, implemented in January 2001, had just over 1,000 individuals enrolled by August. Massachusetts' program aimed to enroll 100,000 people in its first full year, but, after 17 months, premium subsidies provided coverage for only 12,000 people.

Programs have faced reluctance from employers and employees. One obstacle for employers has been the perception that the subsidies are too small to reduce costs significantly. Indeed, recent HSC research found that very large subsidies would be needed to increase insurance coverage by even a modest amount.[4] Some employers do not view providing health insurance as a high priority, and others are suspicious that subsidies will be temporary.

Technical issues also are hampering enrollment. For example, firms with employees whose income varies monthly, such as hourly or commissioned workers, may have workers eligible one month but not the next. Administrative responsibility for the program poses another technical problem. New Jersey's FamilyCare found a solution for this: When a focus group revealed employer concerns about the administrative burden, the program responded by bypassing the employer and sending the subsidy directly to the employee.[5]

From the employees' perspective, workers may not want their employer to know they receive a public subsidy, or they may be reluctant to seek their assistance to enroll in the program. Frequent changes in employment status and fluctuations in monthly earnings present additional obstacles to employees' enrolling. And, most employees have only a narrow window to sign up-during an employer's open-enrollment period. To address this, some policy experts have proposed making eligibility for the program a qualifying event, similar to marriage or birth of a child, that allows off-cycle enrollment.

Despite slow enrollment, there is still optimism that premium subsidy programs have the potential to expand coverage. Experience has shown that cultivating relationships with employers and employees takes time, particularly when a new program is perceived as temporary or vulnerable to funding cuts. Program officials note that planning for slow enrollment-including managing expectations of what these programs can and cannot do-may help build both employers' and employees' confidence and generate greater enrollment over time.

Back to Top

Policy Implications

Premium subsidy programs offer an innovative approach to expanding coverage by leveraging public and private funds and building on the nation's employer-based health insurance system. Yet, initial experience suggests these programs are costly and difficult to design and operate. Moreover, neither employers nor employees have embraced them enthusiastically.

A fundamental issue is the number and complexity of federal and state regulations pertaining to the programs that-while offering important protections-increase costs and reduce the number of potential enrollees. Federally funded programs are subject to requirements and copayments that can increase costs and administrative burdens. At the state level, mandated benefits and consumer protections can make coverage quite costly.

Looking ahead, the combination of a slowing economy, increasingly strained federal funding, state budget shortfalls and rising health insurance premiums could increase demand for premium subsidy programs. Policy makers may need to address difficult tradeoffs between the scope of benefits and the number of people covered if premium subsidies are to serve as a viable way to encourage uninsured, low-income workers to gain coverage.

Back to Top

Notes

1. For a description of other programs, see Silow-Carroll, Sharon, Stephanie E. Anthony and Jack A. Meyer, *State and Local Initiatives to Enhance Health Coverage for the Working Uninsured,* The Commonwealth Fund (November 2000).
2. *Medicaid: Three States' Experiences in Buying Employer-based Health Insurance,* U.S. General Accounting Office, GAO/HEHS-97-159 (July 1997).
3. Silow-Carroll, Sharon, *Employer Tax Credits to Expand Health Coverage: Lessons Learned,* Economic and Social Research Institute for The Commonwealth Fund (February 2000).
4. Reschovsky, James D., and Jack Hadley, *Employer Health Insurance Premium Subsidies Unlikely to Enhance Coverage Significantly,* Issue Brief No.46, Center for Studying Health System Change (December 2001).
5. *Coordinating State Children's Health Insurance Programs with Employer-Based Coverage: Design and Implementation of Premium Assistance Programs-Conference Highlights and Related Information,* Institute for Health Policy Solutions and the National Governors' Association (Oct. 5, 1999).

Back to Top

ISSUE BRIEFS are published by the Center for Studying Health System Change.

President: Paul B. Ginsburg
Director of Site Visits: Cara S. Lesser
Editor: The Stein Group

Health Care, The Problem

Presented by Project Design

Employers Purchasing Alliance®

ALLIANCE

JOINING TOGETHER
TO BUY BETTER®

1) We need to adjust our thinking pattern with regard to content of Health Care Plans. (i.e. Consumer Driven Model's, as well as, Employer Driven Decisions.) Both need to be part of the mix.

2) Insurance is a Commodity and as long as it is so, it needs to be aimed squarely at the consumers it is designed for. i.e.:
   a. Individual Plans
   b. Small Group Plans
   c. Large Group Plans

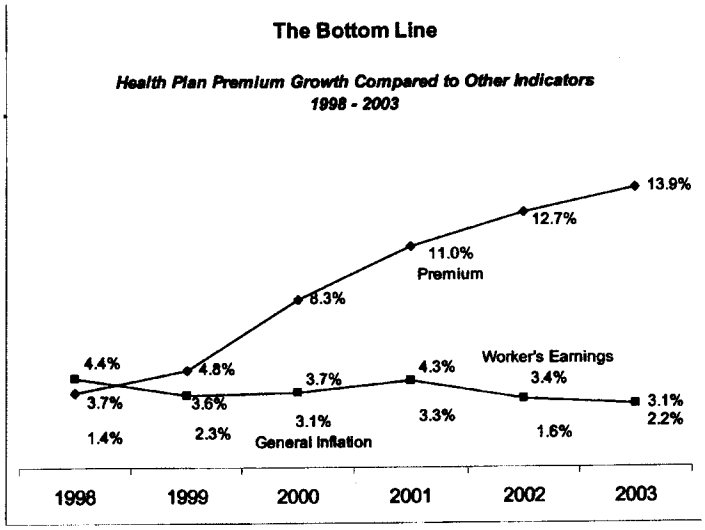
All of the above plans should have options for the participants to chose from ranging from limited coverage to full coverage. Most current plans have various options already, but we still have the problem of cost. There is only certain ways to reduce these costs.

1. Eliminate Certain Coverages
2. Reduce certain coverages
3. Re-price the service cost's
4. Make the plans fit the consumers need in the three areas of "Individual", "Small Group" and "Large Group"

You would think this is being done at present with all the options currently available, but we are still getting the same feedback, it's too Expensive. I believe carriers should be made to quantify the cost of current and future mandates they currently do not seem to want to make that effort. I believe we should have mandates as options "not one size fits all".

The small group market is being strangled with current rating methodology due in part to stipulated mandates, claims experience on certain size groups. The fact is, we need a risk pool to isolate these problem cases, it's so obvious it would go a long way to solving the problem.

With 62% of covered Floridians in HMOs and 38% in Insurance/Carriers, the major burden falls on the managing care providers to reduce costs.



I would like to say that the whole problem is not the responsibility of the insurance world. We need the doctors to re-evaluate their cost of service, we need hospitals to re-evaluate their cost of service, we need drug manufacturers to evaluate their cost to the street prices, and we need Tort reform to control the cost of claims.

Mr. Peter Nolan
Vice President of Project Design
Employers Purchasing Alliance, Inc.

Educated in Dublin Ireland, Christian Brothers College, Dublin.

Product Plan Design Consultants

EHC Advisory Board

Member of the National Association of Health Underwriters

Past President of Florida West Coast Association of Health Underwriters.

Founding Past President of the SunCoast Association of Health Underwriters.

Fellow of the British Insurance Institute.

Peter has testified in Tallahassee regarding legislative changes and initiatives.

Peter is currently advising on health care issues through The House Select Committee on Affordable Health Care for Floridians.

Employers Health Coalition, Inc.

Value Based Solutions

History of Coalition Participation In: Affordable Health Options in Florida

1) Hillsborough – Medically Indigent Program – Original Architect (Employers Health Coalition)

   - 1st Draft – June 1987
   - 2nd Draft – August 1988
   - Final Proposed Draft – February 6, 1989
   - Resolution of County Board of Commissioners – Created "Hillsborough County Advisory Board" May 1990
   - Plan with Advisory Board input – September 3, 1991

   Funding: ½ Cent Hillsborough County Sales Tax

   Number of Participants per Year: 27 – 28,000

   Total $$ Used Per Year – (½ Cent Sales Tax): $85,000,000

   Average $$ spent per participant per year = Range $3,036 - $3,148

2) Florida Small Business Health Access Act
   Served on original Board 1987 – 1990

   - Served Employers with less than 19 employees
   - **Funding:** Robert Wood Johnson initial Grant, plus State Subsidy for two years per Employer.
   - Participants – 10,000 Employers in Florida
   - Ranked the Number One National Model by Robert Wood Johnson Foundation
   - CHPA's forced a merger with Access Employers and its savings of $5 Million was used by AHCA to market CHPA's.

Non-Profit Alliance Health Plan

3) Proposed – Limited Benefit Program for those who cannot afford individual and/or family coverage. Not designed to replace current coverage.

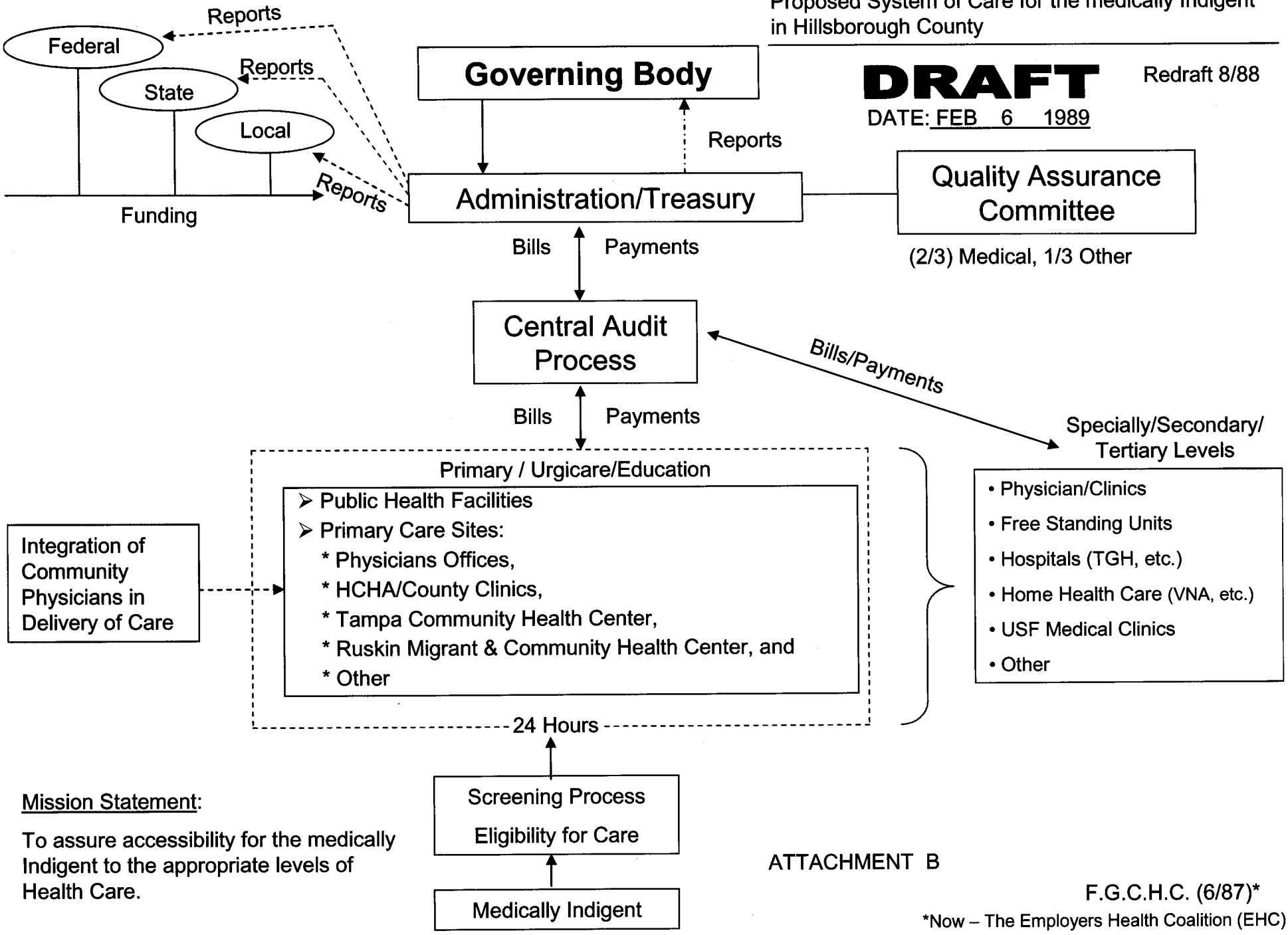
   While not a major medical plan, it does provide provider access and discounts; as well as, supplemental payments to the provider, (many of whom currently received little or no payments).

   Funding: An initial 2-year subsidy from the State to initiate the program and upgrade from a Limited Benefit to Major Medical Offering and for participants/employers to underwrite the cost of the plan in year three and on.

Proposed System of Care for the medically Indigent in Hillsborough County

DRAFT Redraft 8/88

DATE: FEB 6 1989



Mission Statement:

To assure accessibility for the medically Indigent to the appropriate levels of Health Care.

ATTACHMENT B

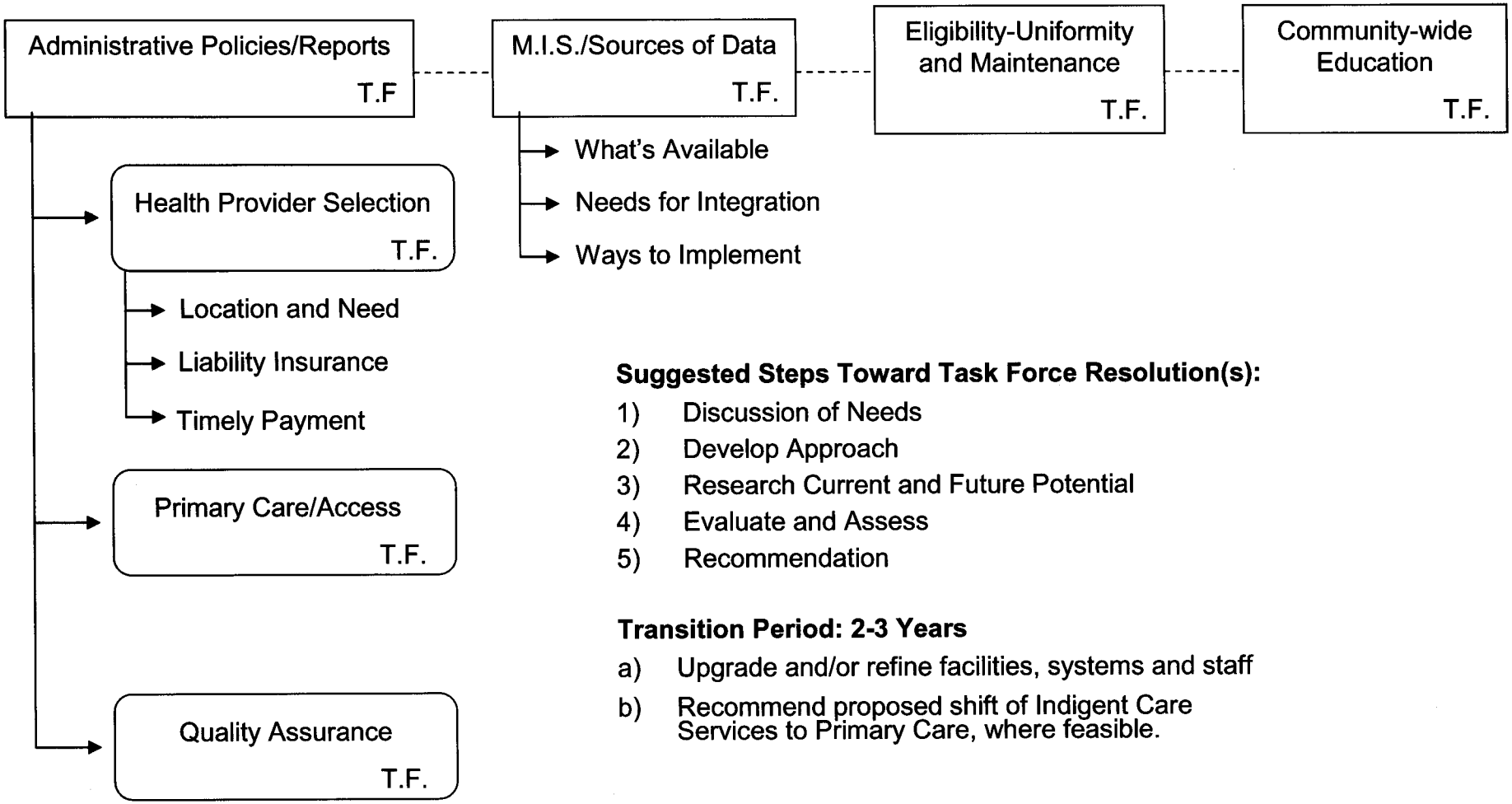
F.G.C.H.C. (6/87)*

*Now – The Employers Health Coalition (EHC)

Table of Proposed Tasks & Transitions

DRAFT

DATE: FEB 6 1989



Suggested Steps Toward Task Force Resolution(s):

1) Discussion of Needs
2) Develop Approach
3) Research Current and Future Potential
4) Evaluate and Assess
5) Recommendation

Transition Period: 2-3 Years

a) Upgrade and/or refine facilities, systems and staff

b) Recommend proposed shift of Indigent Care Services to Primary Care, where feasible.

Note: T.F. = Task Force

ATTACHMENT A

EHC
Employers Health Coalition, Inc.
EMPLOYERS UNITING TO ACHIEVE HIGH VALUE HEALTH SOLUTIONS

February 7, 2003

Representative Frank Farkas

The Employers Health Coalition, Inc. is a non-profit employer membership organization that works to help employers and the community at large, achieve accessible, high value health solutions. It has been recognized over its twenty-year existence both on a local and national basis for its achievements in programs which have benefited employees, their families, the uninsured via "The Indigent Model Plan for Hillsborough County" and the community at large. We are excited to have met the criteria of a non-profit Florida Purchasing Alliance. Our members were extremely pleased with the preliminary work, which has been done by the Florida Legislator to help not-for-profit employers health alliances develop programs, which will target the 2½ million uninsured people in Florida today.

We all realize the lack of affordable coverage for part-time employees, as well as, full time employees working for small companies, that cannot afford to cover their families is a problem for both employers and taxpayers in general. People wait for an illness to become critical before seeking care is always more expense than early treatment. The State indigent care programs are already under stress without the problem of increasing the number of uninsured people. In addition to many programs, which serve employers and Florida communities, the Employers Health Coalition has acted as a not-for-profit community health purchasing alliance, helping employers study and improve health delivery systems for many years including the uninsured or working poor. Now we will be able to help smaller members as well.

Now through your efforts we are looking forward to being able to help small employers obtain affordable coverage for their employees, while at the same time offer family coverage at an affordable price.

We need your help in several ways in order to help the greatest number of uninsured people as possible.

1. Financial support to help develop a cost effective program and communicate it effectively in writing to as many small employers and uninsured in the six county Tampa Bay region.
2. Financial assistance to help in the initial growth years with either partially insuring and/or purchasing stop-loss (re-insurance) to help make the product more affordable while we build critical numbers of covered people with experience information.
3. A further review of what might be done to make the basic program(s) more affordable to the targeted population(s) of small employers and the uninsured in Florida.

We look forward to working together in reducing the number of uninsured impacting State and Federal budgets, while improving the health and wellness of our citizens.

Sincerely,

Dr. Frank M. Brocato

Frank M. Brocato, M.S.H.A., D.Min.
President/CEO – EHC
(A Florida Purchasing Alliance)

Mr. Peter Nolan
President/CEO
Westland Row Group, Inc.

EHC
Employers Health Coalition, Inc
Value Based Solutions

Employers Uniting to Achieve High Value Health Solutions

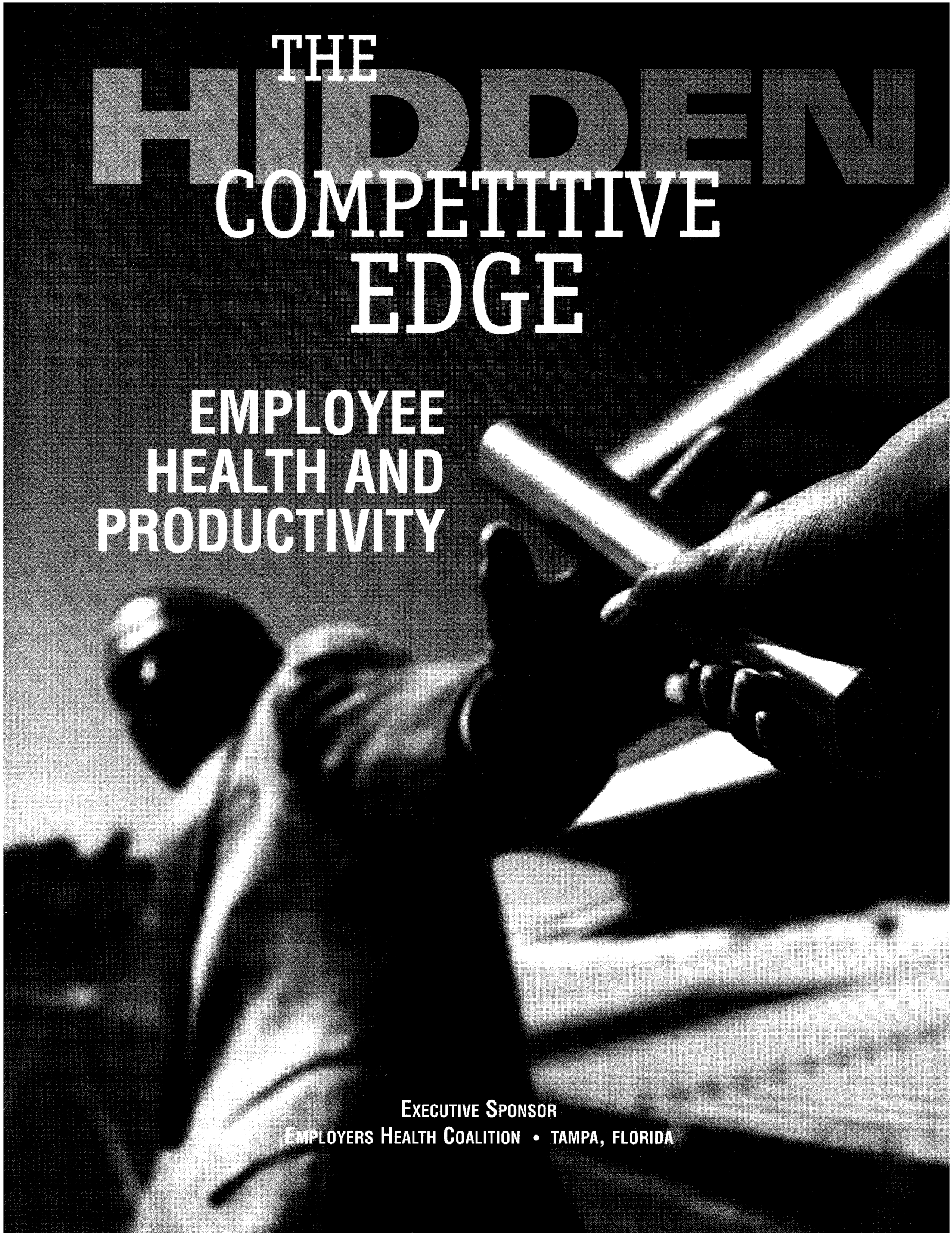
A Brief Overview of Dr. Frank M. Brocato

Dr. Brocato has been the President/CEO of the Employers Health Coalition (EHC – a non-profit 501(c)4 corporation) since its inception in 1983.

- EHC Represents 140 Members and 350,000 Employees and Dependents in 22 counties along the West-Central Coast of Florida.
- These Employers spend Premiums totaling $750,000,000 per year.
- EHC has been recognized locally and Nationally as one of the top 5 Purchasing Coalitions and most recently as the top survey Process dealing with the Health & Productivity of employees at work (presenteeism).

Dr. Brocato obtained his B.S. in Administration at Delta State University, Cleveland, Mississippi, Masters in Hospital Administration at the University of Alabama in Birmingham, Alabama and his Doctorate of Ministry at Faith Outreach Seminary in Tampa Florida.

Employers Health Coalition • 1111 N. Westshore Blvd., Suite 608 • Tampa, FL 33607-4702 • (813) 281-5665 • Fax: (813) 286-2730
www.ehcaccess.org • ehc77@ehcaccess.org


THE
HIDDEN
COMPETITIVE
EDGE
EMPLOYEE
HEALTH AND
PRODUCTIVITY
EXECUTIVE SPONSOR
EMPLOYERS HEALTH COALITION • TAMPA, FLORIDA

The Changing Face of U.S. Health Care

In the past few decades, U.S. health care has undergone dramatic change, mostly for the better. Consumer awareness has increased enormously through health education sources in the workplace, the media, the Internet, and physician practices. There has also been movement away from solely curative treatments to care focused on prevention and healing resources. In addition, advances in technology and research—many of which were pioneered in the United States—have spawned a whole new generation of detection, diagnosis, and treatment techniques whose value is becoming known around the world.

Despite these improvements, however, some fundamental flaws in the way we view health care still exist. For instance, health care is still seen as a commodity by many payors and providers. Driven by bottom-line expense figures, many purchasers still obtain health care based on lowest unit cost, giving less weight to quality and value. This price sensitivity persists mainly because of a lack of appropriate data comparing the cost and value of individual providers, procedures, and treatment methods. Benefit plans deliver care based on price. Their methods include pre-approval processes, case reviews, gatekeepers, and formularies. Costs are also shifted to employees through co-pays and deductibles.

Investing in Health Care: What Employers Want

Until alternative data on value are available, employers will continue to choose health care based on price. Collecting and validating data on the true value of different health care methodologies are critical to correcting this fundamental flaw. The first step is to define what employers want from the health care they purchase. Most employers would agree to five basic outcome elements:

- Faster recovery (fewer inpatient days and reduced overall medical costs)
- Improved quality of life (at work and home)
- Increased functional status (at-work productivity)
- Gains in productivity (less absenteeism)
- Decreased impairment at work (at-work productivity)

While many studies have examined the outcomes of given treatments, most focused only on death rates, length of stay, complications, and need for re-treatment. Today, new methods are going farther, looking into the true value of therapies by comparing individual treatments based on cost, quality, patient satisfaction, and impairment while on the job. These methods are sometimes called disease management or business models. By whatever name, their ultimate goal is the same: to demonstrate the value (in terms of return on investment) of medical efforts to improve employee productivity and quality of life. Value, as these models define it, is the right blend of price, quality, and customer satisfaction.

At-Work Productivity—The Missing Link in the True Cost of Illness

The conventional way employers measure lost productivity is through absenteeism, or lost days. This information is fairly easy to capture using internal data and is applicable to almost any type of business. In manufacturing industries, lost productivity may also be measured in terms of decreased production, such as a decline in the number of units produced in a given time frame.

However, until recently, no one was capturing the cost of slower performance by employees who came to work yet were not able to perform at 100% due to lingering illness or impairment. **As you will see later in this report, capturing this impairment-at-work information is absolutely critical for determining the actual cost of a given illness, because impairment at work can generate up to thirty times more lost productivity than absenteeism.**

Discerning the difference between absenteeism and impairment at work is paramount in determining the actual impact of a given illness, injury, or treatment method. Yet data on impairment at work are only discoverable through direct questioning of employees and observing their at-work performance. One especially effective way to capture this data has been through confidential survey tools provided by the managed care organization or employer. Physicians have always used patient reporting of symptoms to reach their diagnoses, and self-reporting of at-work impairment by employees is proving to be a valid and reliable tool for determining the actual impact of illness on at-work productivity.

These productivity impairment assessments can then be extended across a wide range of diseases, occupations, and businesses for which typical data on absenteeism and production units lost have been inadequate. With the ability to compute actual time lost at work due to a given illness, condition, injury, or treatment, employers can gain an even clearer picture of the bottom-line costs. This is exactly what a group of progressive employers is doing in Florida, under the guidance of the Employers Health Coalition, Inc.

The Employers Health Coalition, Inc—A Catalyst for Change

Located in Tampa, Florida, the Employers Health Coalition, Inc.

(EHC), was initially created as a nonprofit organization in 1983 by a group of local employers and the Greater Tampa Chamber of Commerce. Its mission has always been to improve the quality and cost of health care delivery through value-based solutions.

For example, in the 1980s, most hospitals in the Tampa Bay area based procedure prices on whatever the market would bear. Local employers were complaining—and rightly so—that health care was the only service they purchased without competitive bidding or cost/quality evaluation. They wanted more information on quality, and EHC set out to provide it for them.

EHC began with an ambitious claim analysis project to help uncover the costs of similar procedures among different medical providers. EHC was the first employer coalition in Florida to case-mix adjust provider prices based on severity of cases. EHC learned that higher price doesn't always mean higher quality. Armed with this information, employers encouraged local hospitals to reevaluate the way they charged for various procedures.

After addressing price, EHC turned its attention to outcomes of care. In the mid-1990s, EHC initiated a voluntary, collaborative effort among eleven local hospitals to examine the outcome of care received by patients. The three-year project was the largest voluntary study of its kind. Recognizing the incompatibility of reporting systems among the participating hospitals, EHC convinced each hospital to purchase, install, and use software developed by MediQual and to agree on medical criteria for quality.

This partnering approach paid off in a big way. For the first time, employers were able to review outcome data that were consistent across the eleven hospitals, which represented over half of the employers' insured populations. Because they were comparing apples to apples, employers could easily identify quality-of-care differences among hospitals using local and national databases. In turn, hospitals were able to identify the best practices and strengthen areas that needed improvement. The study also promoted the sharing of ideas and information among physicians, hospitals, and employers. (Some hospitals not only shared the findings with their patients and doctors but also posted them in public areas for all to see. In addition, EHC employers shared the findings with their employees and the community at large.)

In 1996, with quality and cost quantified, EHC put together a task force to examine patient/customer satisfaction with care provided, the third component in determining value in health care. After looking at other instruments in the marketplace and at employer input, the task force designed a questionnaire to look at the continuum of care and capture the functional return-to-work status of employees after receiving care. Doing so helped the EHC capture, perhaps for the first time, the level of employee impairment by disease both at home and at work. The activities of this task force are extraordinary achievements in defining health care value for employers and are the focus of the remainder of this report.

Across all seventeen *diseases studied in 1999, days lost due to impairment at work (presenteeism), on average, were 7.5 times greater than those due to absenteeism.*

The HEALTHY PEOPLE/PRODUCTIVE COMMUNITY℠ SURVEY—Pioneering Productivity Measurements

While many employers continue to measure productivity losses only in terms of lost days, the EHC's HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY revealed that absenteeism is just the tip of the iceberg. In fact, for the same conditions, the EHC's surveys discovered that impairment at work ("presenteeism") generated much more lost time than absenteeism. Across all seventeen diseases studied in 1999, 3.05 days were lost due to impairment at work (presenteeism), on average, compared with an average .41 days lost due to absenteeism—a ratio of nearly 7.5 to 1.

The following three tables on pages 4 and 5 represent the lost days resulting from each of the seventeen diseases. Table A displays presenteeism, Table B, absenteeism and Table C displays the total lost days generated by presenteeism and absenteeism combined.

The discovery of the impact of illness on at-work performance was proof positive that any health care value equation used by employers should take into account impairment and productivity measures. Productivity and impairment measures using statistical methodology can be successfully added to routine satisfaction and health surveys while maintaining comparative consistency. In addition, a general population approach can be taken to calculate and compare productivity loss assessments across the full range of disease groups and healthy populations.

EHC Survey Purpose and Specifics

As part of its vision for quality health care on a community-wide basis, the EHC developed the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project. Eight progressive employer-members of the EHC participated in the survey in 1998; a ninth employer joined them in 1999. This employer-driven project set out to help participants determine the areas of health care that needed the most attention and improvement. In 1998, ten diseases were selected for close scrutiny. These choices were driven primarily by claims data from the participating employers, as well as other health care sources. In 1999, driven primarily by 1998 survey results on disease prevalence, productivity loss, and costs of lost productivity, the survey was broadened to include seventeen diseases and more health burden measurements.

For both surveys, the EHC contracted with an outside team of consultants, including independent, third-party vendors who validated the format for employee mailing addresses. Florida Medical Quality Assurance, Inc., and the University of South Florida in Tampa helped conduct this validation process. The flow of data collection, analysis, and reporting was structured so as to ensure confidentiality for employers and their employee respondents at all levels of reporting.

Data For Top 17 Disease Categories 1998 vs. 1999

Table A
Average Days Lost Due to Impairment at Work (Presenteeism) Over a 4-Week Period

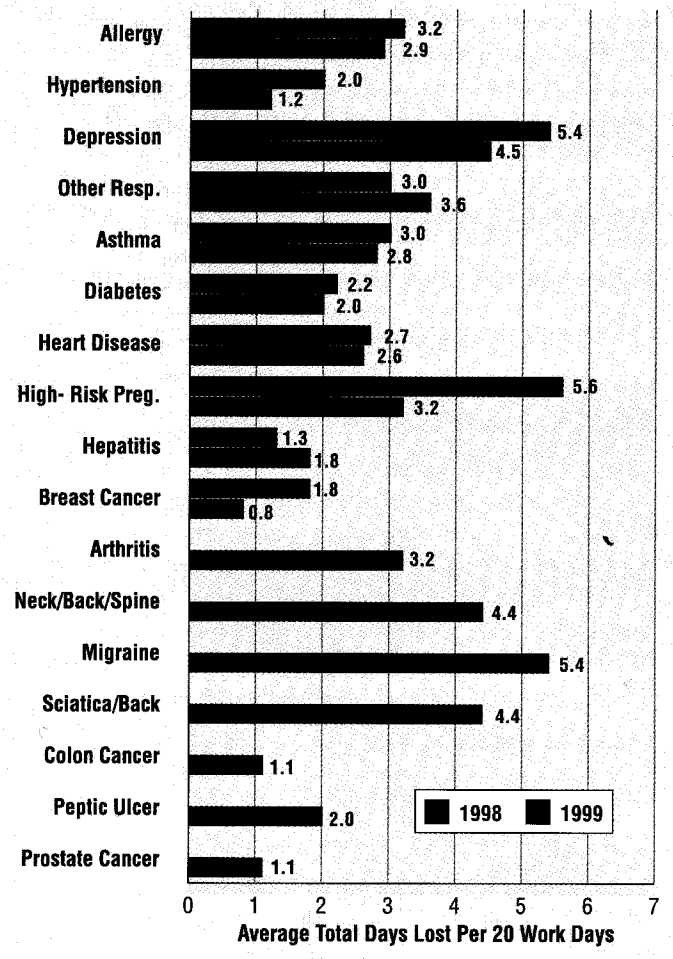
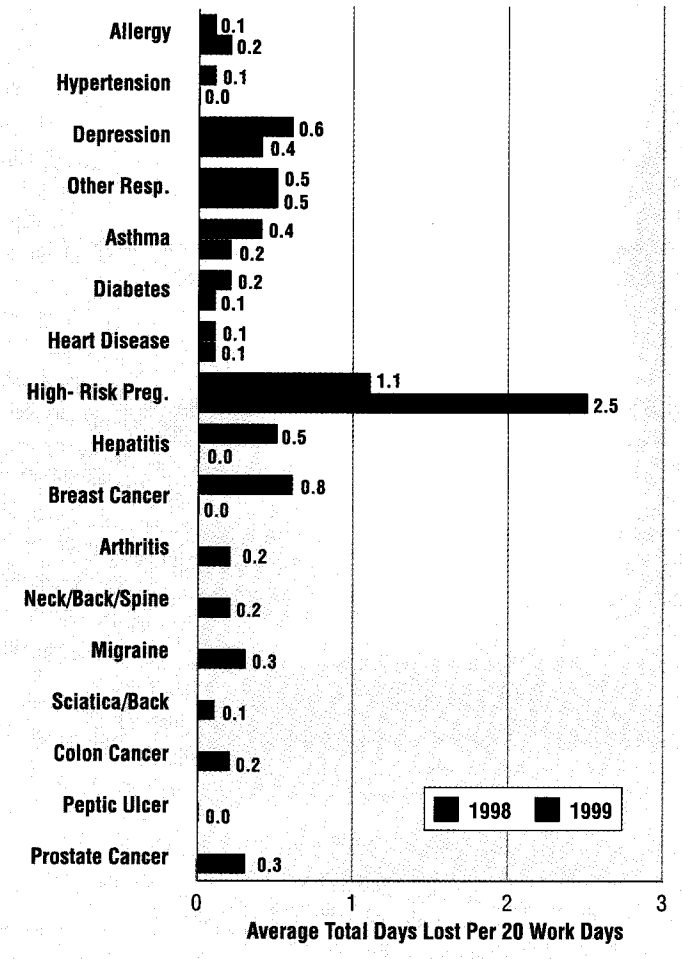


Table B
Average Reported Days Absent Over a 4-Week Period



The Survey Process

In both 1998 and 1999, the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY used a **two-wave** process in which two different questionnaires were distributed by mail to employees and selected household members. This methodology was designed to capture a wide breadth of data that could be used to perform additional population demographic studies beyond the original purpose of the surveys.

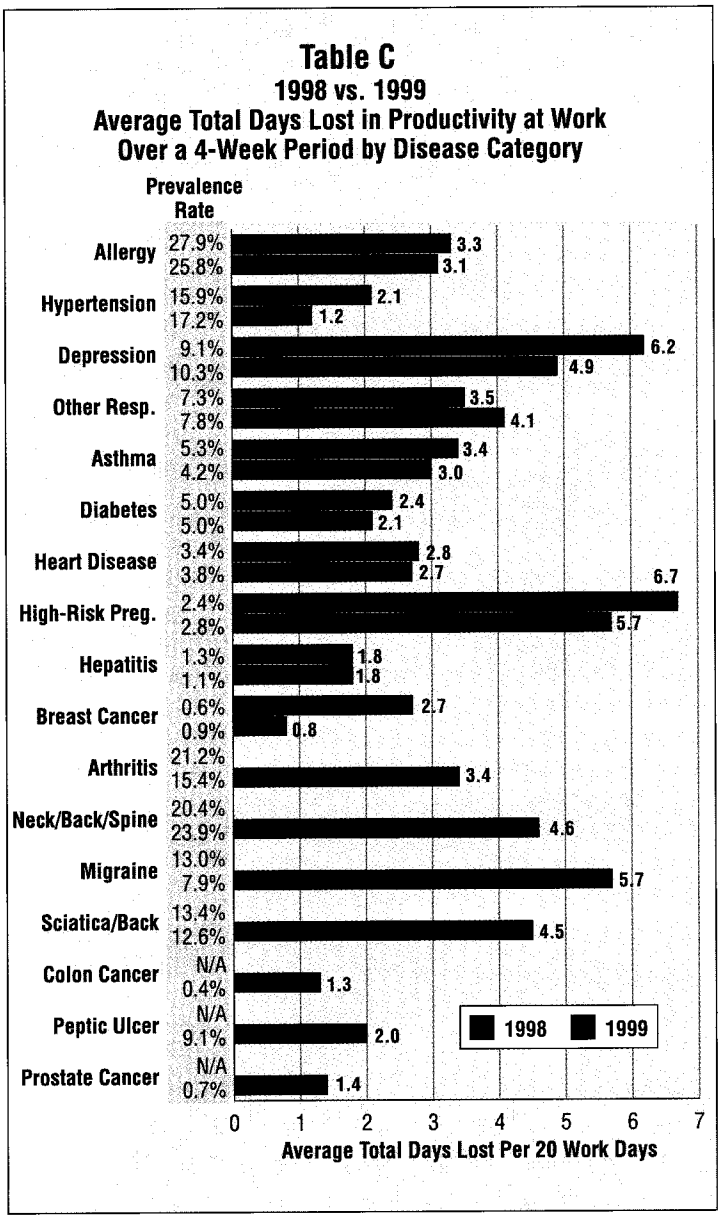
Wave 1 involved a general questionnaire that contained approximately 200 items measuring the following:

- Health status
- Productivity
- Use of traditional and complementary providers
- Doctor diagnosis versus self-diagnosis
- Medication use
- Use of multiple medications (polypharmacy)
- Health risk behaviors
- Job characteristics
- Various dimensions of satisfaction with health care performance

Wave 2 questionnaires contained condition-specific instruments, each with approximately 150 items measuring the following:

- Health status
- Disease severity and quality of life
- Condition-specific questions on productivity
- Medication use
- Use of traditional and complementary providers and perceived outcomes
- Information sources for disease management and health risk behaviors
- Health care process performance and provider practices and communications

For both waves of the survey, a three-step, "mail-out/mail-back" procedure was used, which included (1) the initial general survey, (2) a reminder card, and (3) a follow-up survey. Each was mailed to the employees' homes. Employers played an active role in the survey process, providing enrollment files and sending letters to employees informing them of the project and encouraging their participation. All reporting information



received by employers was at the employer group level, however; at no point did they receive any data that could be linked to the identification of any respondent.

Employees were told that their responses would remain confidential and that the information gained could benefit them and people in their community. These were the only incentives for completing the lengthy questionnaire. (The high response rate indicates that people who completed the survey were concerned about health care and wanted to help do something about it.)

To ensure confidentiality, employers were never provided with specific information on participating employees. Instead, they were told only the total number of employees participating and the average total lost days per disease. In addition, the University of South Florida in Tampa helped EHC review, total, and validate the accuracy of mailing data before they were sent to a third-party survey vendor located out of state.

Final Survey Review and Report Preparation

The EHC HEALTHY PEOPLE/PRODUCTIVE COMMUNITY TASK FORCE was made up of Participating Employers: **Cargill Fertilizer, Florida Blood Services, Florida Power Corp., Verizon Communications** (formerly GTE), **Honeywell, Pasco County Government, Pasco County Schools, Pinellas County Government**, and **TECO Energy**; EHC Staff: President and CEO, **DR. FRANK M. BROCATO**, Director of Education and Administration, **CINDY SCHOPMEYER**; Consultants: **DR. SPENCER BORDEN** of Integrity Consulting, LLC, **DR. HARRIS ALLEN** of Harris Allen Associates, **DR. R. JOYCE BARNES** of Tri-M Associates Consulting; and Grantors (nonvoting members of the task force): **Schering-Plough Corporation, Ortho-Biotech** (Johnson & Johnson), and **Roche Laboratories**.

Headed by Dr. Frank M. Brocato (representing the Executive Sponsor), the taskforce was responsible for overseeing the multiyear project, including strategic planning and setting time-tables. Great care was taken by the taskforce to keep the project employer designed and driven, while keeping all information confidential, objective, and user-friendly. The task force served as a liaison between employers and third-party participants, keeping track of and facilitating the exchange of collected data.

DataStat, a third-party vendor, performed the mailing of the individual surveys, received and inputted survey data, tracked response rates, and submitted the raw aggregate data collected to EHC. With the help of consultants and Florida Medical Quality Assurance, Inc., EHC analyzed the aggregate data and formatted findings into information that was both meaningful and useful while maintaining objectivity and confidentiality. Bar graphs and charts were created by Cindy Schopmeyer and reviewed for accuracy by the taskforce, who was also charged with initiating the study, reviewing data, and presenting study information to the public.

Selected Diseases and Unexpected Discoveries

The following is a list of the seventeen adult and two pediatric disease categories targeted by the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project. Diseases were selected based on employer input, claims data, and prior survey results.

- Allergy (adult and pediatric)
- Arthritis
- Asthma (adult and pediatric)
- Breast cancer
- Colon cancer
- Depression
- Diabetes
- Heart disease
- Hepatitis
- High-risk pregnancy/C-section
- Hypertension
- Lower back pain/sciatica
- Migraine
- Neck/upper back/spine conditions
- Other respiratory conditions
- Peptic ulcer/acid reflux disease
- Prostate cancer

Table D

Baseline Norms on Key Measures
1998 & 1999 Combined Averages

	Total Responders Average	Same Responders Average	Baseline Norm for 1998-1999
Health			
Overall Physical Health	50.8	50.9	50.9
Overall Mental Health	51.6	52.0	51.8
Productivity			
Loss due to Impairment over a 4-Week Period	2.9	2.7	2.8
Loss due to Absenteeism over a 4-Week Period	0.5	0.4	0.4
Total Productivity Loss over a 4-Week Period	3.3	3.1	3.2
Health Care Process			
Outcomes of Care	60.1	61.6	60.9
Costs & Coverage	55.7	57.2	56.5
Overall Care	74.9	76.2	75.6
Overall Plan Satisfaction	69.7	70.1	69.9

Overall, the goals of the project are: to measure employee experiences in relation to the seventeen disease categories; compare the impact of these seventeen conditions on health, productivity, and use of the health care system; and access and compare the performance of the health care system in caring for each of the seventeen conditions.

Survey data gathered on the seventeen diseases were used to identify and prioritize potential areas for improvement in both the health and health care of groups with a given condition. In addition to employer-specific reports, participating employers, providers, and health plans are using the aggregate data to develop and implement community-wide interventions to address areas of concern or opportunity, including:

- The fact that many diseases with seemingly "low" direct medical costs turned out to be major sources of productivity losses due to their prevalence and impact on affected workers;
- *The prevalence of allergies and the productivity impact of using sedating versus nonsedating medications (e.g., based on the Tampa data, employees with allergies who use nonsedating medications appear to have saved an average of 500 to 675 days per year per thousand employees compared with those who use sedating medications);*
- The impact of depression and the value of early diagnosis and treatment, including patients with terminal illnesses who return to work;
- The emerging epidemic associated with hepatitis C (the prevalence of hepatitis C was almost twice that of breast cancer);
- The value of managing asthma as a chronic disease;
- The co-morbid effect of body mass on diabetes, hypertension, and heart disease;
- The level at which smoking exacerbates respiratory disease and other related diseases; and
- The value of exercise among arthritis sufferers, overweight individuals, and those with hypertension.

In addition, the self-reporting aspect of the survey has helped provide critical proof of patients' ability to accurately report their health status. Self-reporting was the information-gathering methodology used in both wave 1 and wave 2 surveys in 1998 and 1999. Out of more than 6,000 responses, 2,220 completed wave 1 questionnaires in both years. Table D, Baseline Norms on Key Measures, shows the high degree of consistency of self-reporting disease conditions over the two years, thus providing evidence of the integrity and reliability of this methodology.

Table E, Self-Diagnosis Add-On, provides additional insight into which diseases were supported by a physician diagnosis and which were not reported through the claims process. It is interesting to note here the increases in prevalence brought on by self-reporting for conditions such as allergy, depression, arthritis, migraine, heart disease, neck/back pain, and certain cancers.

Another interesting finding of the project was the perceived effectiveness of treatment by complementary providers. A significant number of participants sought help from nontraditional providers, especially for low back pain/sciatica and neck/upper back/spine conditions, and these providers received higher ratings than traditional providers in relieving discomfort. However, the overall

Table E
All Diseases - Increase in Disease *Prevalence*
Due to the Self-Diagnosis Add-On
(Wave-1)

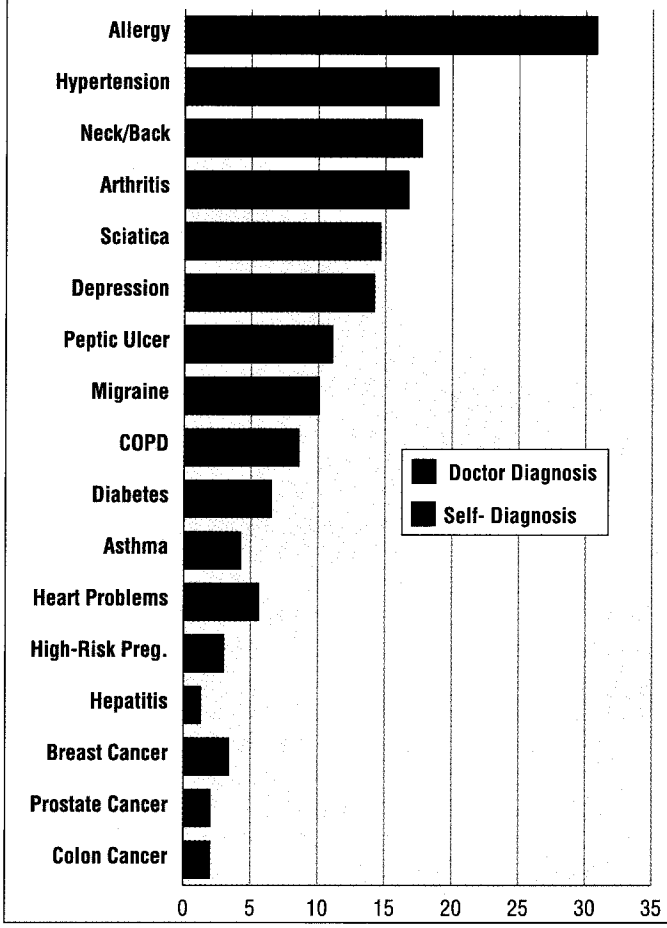
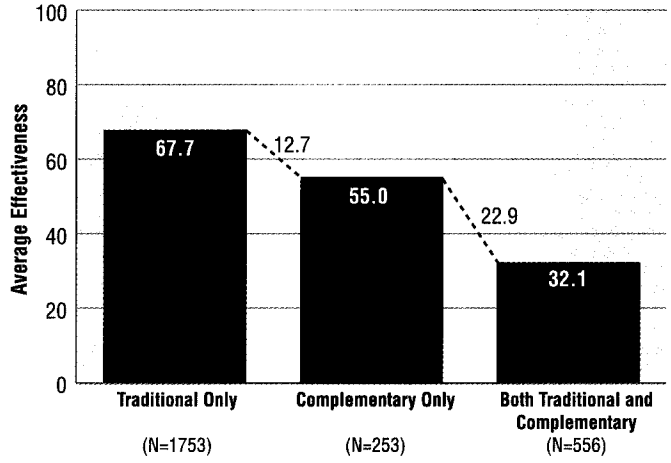


Table F
All Diseases
***Effectiveness* for Relieving Discomfort**
Traditional vs. Complementary Therapies (Wave-2)



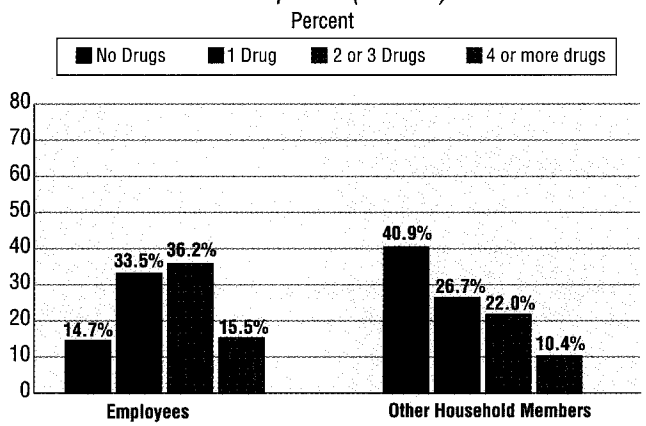
average for all seventeen diseases among complementary providers was not as high as that for traditional providers (See Table F).

Due to study findings, participating employers are now examining other, more sophisticated issues. Examples include the prevalence and lost days associated with hypertension and high-risk pregnancy, as well as the high prevalence and pharmacy costs associated with individuals with peptic ulcer/acid reflux disease.

After the 1998 HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY results were tabulated, employer feedback and the Continued Quality Improvement (CQI) process raised new issues to be explored. To address the new topics of interest, the 1999 survey was expanded to explore such issues as these:

- **Polypharmacy**—the use of multiple prescription and over-the-counter drugs. In 1999, polypharmacy was prevalent among participants, with over half (51.7%) of employees reporting taking two or more prescription or nonprescription drugs. (See Table G.)

Table G
All Diseases
***Number of Drugs*[1] taken by Employees or Household Members with One or More Chronic Conditions**
All companies (Wave-1)



[1]Included both Prescription and Non-prescription Drugs

- **Traditional versus complementary provider care**—comparing usage and effectiveness for traditional and complementary care. (See Tables H and I.)
- **Productivity versus pharmaceuticals**—the effectiveness of specific classes of medications and their impact on productivity. Initial analysis of several medication classes suggested that some medications improve employees' at-work performance more than others.
- **Job classification**—the varying impact of diseases on different job classes in terms of lost productivity and number of disease conditions. Identifying disease conditions by job classification is important in calculating compensation, production, and revenue losses, as well as in targeting groups for prevention education.

Table H
All Diseases
Total *Number of Visits* to Traditional vs. Complementary Providers
All companies (Wave-1)

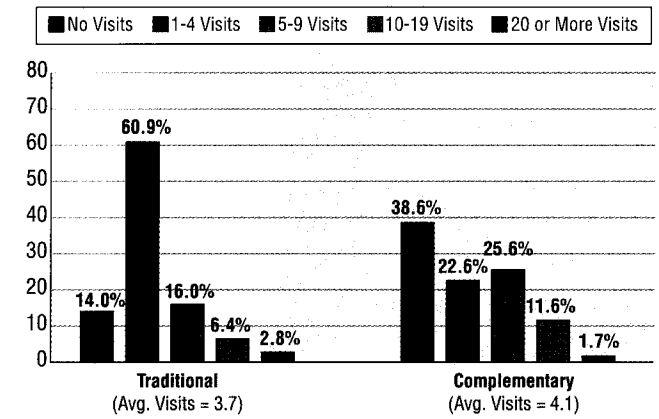


Table I
All Diseases
Self Reported *Outcomes of Care* by Type of Provider
All companies (Wave-1)

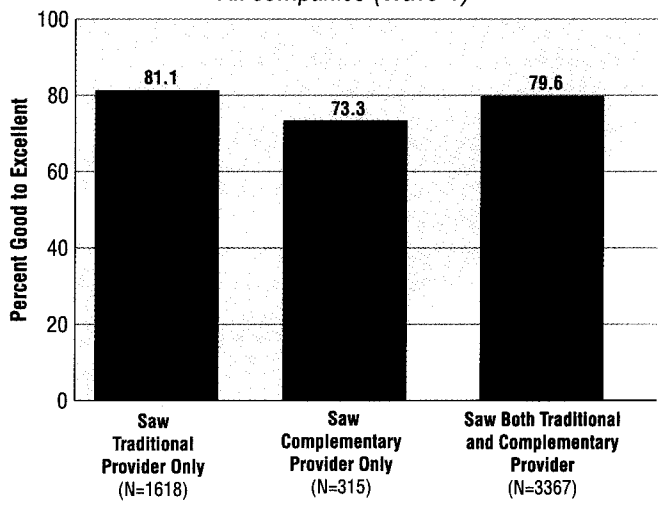
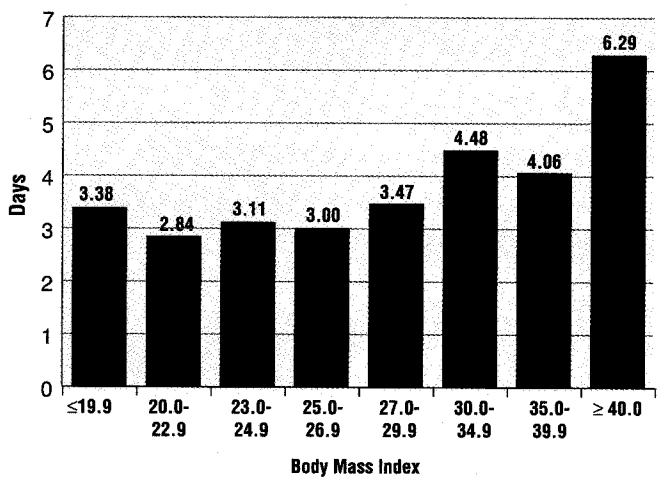


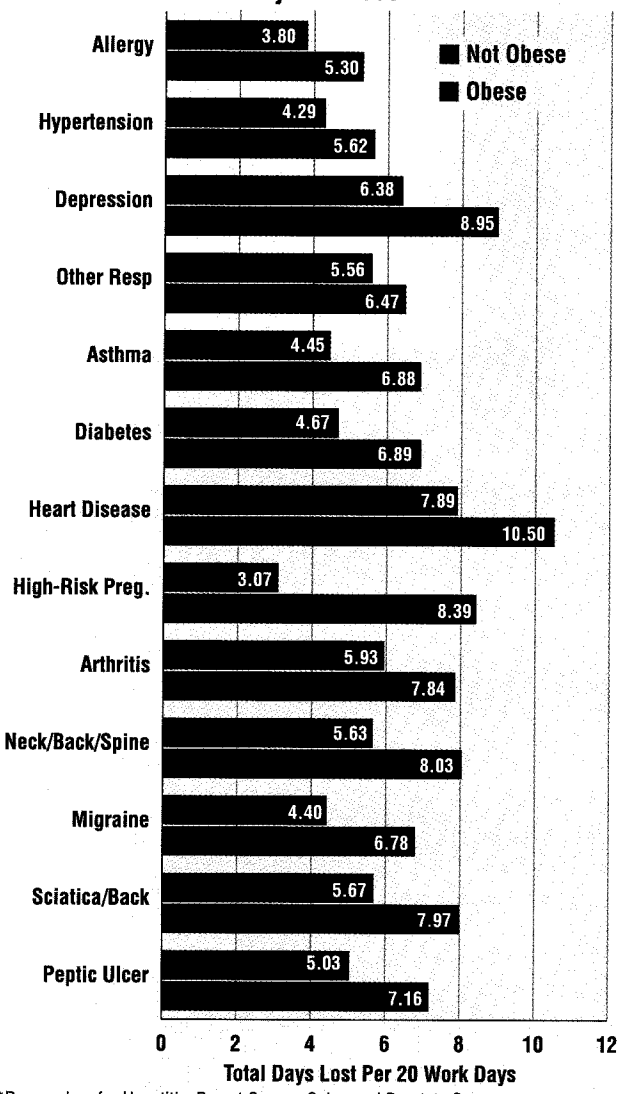
Table J
Total Days Lost by Body Mass Index[1]
1999, Over a 4-Week Period



[1]Weight Kilograms/Height Meters[2]

- **Physician diagnosis versus self-diagnosis**—the impact of self-diagnosis on the prevalence and expense associated with diseases such as allergy, depression, arthritis, and neck/back pain. The 1999 data revealed that self-diagnosis was much higher among certain disease groups.
- **Body mass index**—the relationship of body weight as measured by body mass index (BMI) to productivity (as presented in Tables J and K). Based on the total days lost during the four-week period, there appears to be a strong relationship between increasing BMI and the number of days lost from work. In reference to Table K, of the 13 targeted conditions with an adequate number of respondents, 92% of the conditions in obese (BMI ≥ 30.0) population reported a significant increase in productivity loss compared to non-obese (BMI ≤ 29.9) respondents. On average, for the 13 conditions, obese individuals lost 1.4 days more in a 20-day period compared to the non-obese individuals. Further research needs to be done to investigate this relationship as well as the appropriate application of available resources to further improve productivity.

Table K
Average Total Days Lost for Those at Risk for Being Overweight by Disease for 13 of 17 Diseases* Surveyed in 1999



*Responders for Hepatitis, Breast Cancer, Colon and Prostate Cancers were too small for comparisons

The 1998 and 1999 Surveys—Key Findings

One of the factors that make the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY unique is that it measures not only absenteeism caused by specific diseases but also "presenteeism"—*lost productivity while on the job.* The survey technique allowed *all* workers to respond to questions on impairment at work (presenteeism) without regard to job title or activity at work. Each year, surveys included a five-item battery on how illness affects individual work accomplishments or interaction with peers. This cutting-edge methodology yielded fascinating information on how different conditions affect workplace performance.

For example, the survey revealed that presenteeism accounts for more lost productivity hours than absenteeism and that conditions such as allergy, depression, and high-risk pregnancy have the greatest impact on at-work performance. (See Tables N and O, page 10.) In fact, for the same conditions, impairment at work (presenteeism) accounted for much more lost time than did absenteeism. Across all seventeen diseases studied in 1999, 3.05 days were lost due to impairment at work (presenteeism), on average, compared with an average of .41 days lost due to absenteeism—a ratio of nearly 7.5 to 1.

When the data for 1998 and 1999 were sorted by average lost productivity days per year, migraine and high-risk pregnancy emerged as the conditions causing the highest per-case combination of lost days (absenteeism) and lost productivity while on the job (presenteeism). During a typical four-week period, each migraine sufferer averaged 5.7 lost productivity days in 1999. High-risk pregnancy cases averaged 6.2 lost days per four-week period. (See Table M.)

While migraine and high-risk pregnancy caused the most lost

Table L

Top 17 Diseases Ranked in Priority by Prevalence in the Workplace:

	Prevalence Rate	1999	1998
1. Allergy -			
	An estimated 1 out 4 employees or	25.8%	27.9%
2. Hypertension -			
	An estimated 1 out of 6 employees or	17.2%	15.9%
3. Neck/Upper Back/Spine -			
	An estimated 1 out 7 employees or	15.1%	20.4%
4. Arthritis -			
	An estimated 1 out of 7 employees or	13.9%	21.2%
5. Lower Back/Sciatica -			
	An estimated 1 out of 8 employees or	12.6%	13.4%
6. Depression -			
	An estimated 1 out of 10 employees or	10.3%	9.1%
7. Peptic Ulcer/Acid Reflux -			
	An estimated 1 out of 11 employees or	9.1%	N/A
8. Migraine -			
	An estimated 1 out of 13 employees or	7.9%	13.0%
9. Other Respiratory Conditions -			
	An estimated 1 out of 13 employees or	7.8%	7.3%
10. Diabetes -			
	An estimated 1 out of 20 employees or	5.0%	5.0%
11. Asthma -			
	An estimated 1 out of 24 employees or	4.2%	5.3%
12. Heart Disease -			
	An estimated 1 out of 26 employees or	3.8%	3.4%
13. High-Risk Pregnancy -			
	An estimated 1 out of 36 employees or	2.8%	2.4%
14. Hepatitis -			
	An estimated 1 out of 91 employees or	1.1%	1.3%
15. Breast Cancer -			
	An estimated 1 out of 111 employees or	0.9%	0.6%
16. Prostate Cancer -			
	An estimated 1 out of 143 employees or	0.7%	N/A
17. Colon Cancer -			
	An estimated 1 out of 250 employees or	0.4%	N/A

Employers Health Coalition is committed to focusing on individual company and community-wide effective health interventions which result in greater high-value health solutions and quality of care within the community.

Table M

The Top 17 Diseases Ranked in Priority by Average Total Days Lost in Productivity by Individual Employees Over a 4-week Period in 1999:

	1999	1998
1. Migraine	5.7 Days	N/A
2. High-Risk Pregnancy	5.7 Days	6.7 Days
3. Depression	4.9 Days	6.2 Days
4. Neck/Upper Back/Spine	4.6 Days	N/A
5. Lower Back/Sciatica	4.5 Days	N/A
6. Other Respiratory Conditions	4.1 Days	3.5 Days
7. Arthritis	3.4 Days	N/A
8. Allergy	3.1 Days	3.3 Days
9. Asthma	3.0 Days	3.4 Days
10. Heart Disease	2.7 Days	2.8 Days
11. Diabetes	2.1 Days	2.4 Days
12. Peptic Ulcer/Acid Reflux	2.0 Days	N/A
13. Hepatitis	1.8 Days	1.8 Days
14. Prostate Cancer	1.4 Days	N/A
15. Colon Cancer	1.3 Days	N/A
16. Hypertension	1.2 Days	2.1 Days
17. Breast Cancer	0.8 Days	2.7 Days

With a few exceptions, the rank order among the 1998 top 10 diseases stayed the same, even as the estimated productivity loss for every disease was a little less than last year, except for Other Respiratory Conditions. Seven of the 17 most highly ranked diseases in 1999 were measured for the first time in 1999.

productivity days per individual, the lower prevalence of both migraine (one out of thirteen employees) and high-risk pregnancy (one out of thirty-six employees) helped to buffer the health burden costs associated with these conditions. Instead, allergies, depression, and conditions of the back and spine took the greatest toll and therefore appear to offer some of the best opportunities for disease management.

Another unexpected finding was the prevalence of neck/upper back/spine conditions, arthritis, lower back pain/sciatica, and migraine. Clearly, these co-morbid conditions are worthy of attention in their own right and should not be regarded as secondary ailments associated with major diseases. (See Table L.)

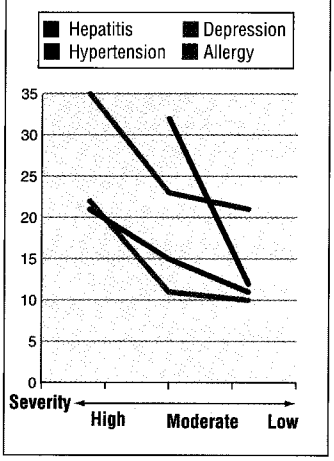
In Tables N and O on page 10, average lost productivity days are multiplied by condition prevalence and salary to provide estimates of the savings possible through proper medical management. The potential saving of managing the ten key diseases in the 1998 survey is $4 million, while proper management of all seventeen diseases surveyed in 1999 would top $7.2 million.

Yet another key finding of the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project in 1998 was the link between productivity loss and disease severity. As demonstrated in Table P, productivity losses increase linearly with severity of a given disease. This increase in lost productivity may be linked to disease severity and medical practices and the management of care and/or coverage issues that fail to yield the best outcomes.

Table P

Disease Severity and Impairment at Work

Percent Impaired at Work



Survey Outcomes—Key Knowledge Gained

There are four especially key insights provided by the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project that could help reshape the way employers and managed care organizations view and purchase health care.

INSIGHT ONE is the importance of accounting for presenteeism, or impairment at work, when measuring the impact of an illness, injury, or treatment

Estimated Potential Savings per 1000 employees

Potential Savings per annum = Average Days Lost X (% of Workforce Affected X Employee Population) X Average Compensation/Day X 13 four-week periods.

Table N 1999

Top 17 Diseases	=	Avg. Days Lost	X	Prevalence	X	Avg. Comp. 8 hrs x $15/hr	X	13 four-week periods	=	Est. Savings
Allergy	=	3.1	X	258	X	$120	X	13	=	$1,247,688
Neck/Upper Back/Spine	=	4.6	X	151	X	$120	X	13	=	$1,083,576
Lower Back/Sciatica	=	4.5	X	126	X	$120	X	13	=	$884,520
Depression	=	4.9	X	103	X	$120	X	13	=	$787,332
Arthritis	=	3.4	X	139	X	$120	X	13	=	$737,256
Migraine	=	5.7	X	79	X	$120	X	13	=	$702,468
Other Resp. Cond.	=	4.1	X	78	X	$120	X	13	=	$498,888
Hypertension	=	1.2	X	172	X	$120	X	13	=	$321,984
Peptic Ulcer/Acid Reflux	=	2	X	91	X	$120	X	13	=	$283,920
Asthma	=	3	X	42	X	$120	X	13	=	$196,560
Diabetes	=	2.1	X	50	X	$120	X	13	=	$163,800
Heart Disease	=	2.7	X	38	X	$120	X	13	=	$160,056
High-Risk Pregnancy	=	5.7	X	28	X	$120	X	7	=	$134,064
Hepatitis	=	1.8	X	11	X	$120	X	13	=	$30,888
Prostate Cancer	=	1.4	X	7	X	$120	X	13	=	$15,288
Breast Cancer	=	0.8	X	9	X	$120	X	13	=	$11,232
Colon Cancer	=	1.3	X	4	X	$120	X	13	=	$8,112
Total of all 17 Adult Diseases									=	**$7,267,632**

Table O 1998

Top 10 Diseases	=	Avg. Days Lost	X	Prevalence	X	Avg. Comp. 8 hrs x $15/hr	X	13 four-week periods	=	Est. Savings
Allergy	=	3.3	X	279	X	$120	X	13	=	$1,436,292
Depression	=	6.2	X	91	X	$120	X	13	=	$880,152
Hypertension	=	2.1	X	159	X	$120	X	13	=	$520,884
Other Resp. Cond.	=	3.5	X	73	X	$120	X	13	=	$398,580
Asthma	=	3.4	X	52	X	$120	X	13	=	$275,808
Diabetes	=	2.4	X	50	X	$120	X	13	=	$187,200
Heart Disease	=	2.8	X	34	X	$120	X	13	=	$148,512
High-Risk Pregnancy	=	6.7	X	23	X	$120	X	7	=	$129,444
Hepatitis	=	1.8	X	13	X	$120	X	13	=	$36,504
Breast Cancer	=	2.7	X	6	X	$120	X	13	=	$25,272
Total of all 10 Adult Diseases									=	**$4,038,648**

method. Impairment at work has proven to be one of the most costly elements of health care to employers, if not the most costly element.

INSIGHT TWO is the validity of measures gained by self-reporting. The reliability and consistency of data gathered over two years and four separate surveys have provided much-needed proof of the validity of data reported by consumers themselves, without assistance by health care professionals.

INSIGHT THREE is the concept of value-based purchasing of health care, as opposed to buying decisions based solely on unit cost. Value-based purchasing takes into account not only the cost of health care but also the quality and customer satisfaction associated with that care. Only by looking at the complete picture can employers make informed decisions on the true value of given units of health care. (See sidebar.)

INSIGHT FOUR is the value of up-front return on investment for

Rising Health Care Costs: A Closer Look

At a time when many managed care organizations are pushing double-digit rate increases, it is important to look into the reasons behind these requests. Many health plans are blaming rising pharmaceutical costs for their rate hikes, explaining that pharmacy costs are increasing at a rate of 20-30% a year. The cost increase of pharmacy is real. But upon closer examination, it appears that the actual impact of pharmaceutical costs has been overstated.

Pharmaceutical costs make up 10-12% of total health care costs, or 10-12 cents of every dollar spent on health care. Therefore, a 20-30% increase in drug costs actually generates an increase of only 2 or 3 cents. That means something else is behind the health plans' rate increases. The point is this: Don't be afraid to question your health plan and demand explanations for any rate hikes.

productivity gains. Employers and managed care organizations that rely mainly on drug formularies and lifetime limits on certain conditions to contain costs may be shortchanging themselves and their employees. For example, the decrease in at-work performance of allergy sufferers caused by over-the-counter, sedating antihistamines is far greater than the cost of providing prescription, nonsedating drugs. Also, limits on mental health benefits can discourage depressed workers from seeking help, thus robbing employers and workers of valuable productivity.

OTHER KEY INSIGHTS gained from the survey project include:

- The unmistakable impact of employee education and communication and the important role employers play in this;
- The importance of using a nonadversarial approach with pharmacies, managed care companies, health plans, hospitals, and employee benefit consultants;
- The need to develop employers' roles so that they become value purchasing champions;
- Involving all stakeholders in a community offers the best chance of improving productivity, health, and quality of life;
- The realization that household members' health can contribute to employees' loss of productivity at work;
- The fact that when purchasers speak, the rest of the system listens;
- The key role of feedback and engagement by all participants and the importance of follow-up by providing survey result information to all employees of participating employers.

Final Thoughts and Lessons Learned

The HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY process has shed much light on the effects various health conditions have on employees in the workplace. One clear message from the project is that continuing to focus solely on the traditional "high-cost" health care procedures is not the best approach. As disease management matures and additional studies are conducted, it is becoming apparent that a more integrated approach that combines productivity losses with units of medical cost is more likely to yield substantial savings for employers and a more accurate means of measurement.

For example, claims costs can't be relied upon to tell the whole story in the case of allergies. Allergies were far and away the most prevalent reported condition for both years of the survey. And while the costs of medical treatments for allergies are much lower than the costs for conditions such as heart disease and prostate cancer, allergies can be devastating for worker productivity. The sheer prevalence of the disease (affecting one in four employees) added to average total days lost puts the potential estimated savings for managing allergies at $1.25 million per thousand employees—compared to $160,000 for heart disease and $15,288 for prostate cancer. (See Tables N and O, Estimated Potential Savings chart, on page 10.)

Other lessons learned during the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project focus on the process itself. We have discovered that in order to successfully explore the elements that make up value-based health care, there must be clear leadership and employer consensus on the data and goals desired. Also, careful planning and execution are vital. The community approach, which involved providers, employers, employees, and dependents, was another key to the success of this project, as was ensuring the confidentiality of the information with employer support and assurances of confidentiality.

Regarding the information gathered, the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project broke new ground in the use of data self-reported by the participants. The consistency of data reported by the same individuals over a two-year, four-survey process helped prove the validity of such an approach compared to similar data collected from claims. Also, the consistency of the data analysis process added credibility to the project.

EHC: Future Goals, Future Survey Projects

The Tampa, Florida–based HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project can serve as a model for a nationwide initiative. The EHC now plans to roll out the program in other parts of the United States and has already begun work in Arizona and Louisiana. Additional opportunities to work at other sites and with employers around the country are also under way.

EHC is also actively seeking financial sponsors for its expanding program as well as new partnership opportunities. The proprietary nature of EHC's methodology and survey instruments makes the program unique and therefore available exclusively to EHC sponsors and participants. For those interested in learning more, the EHC can present survey results in several formats. Speaking engagements can be arranged, and publications of select survey data and findings are available. Video and other media will also be available soon.

ROI Project: EHC's newest project involves developing a consistent return on investment (ROI) Business Model for

employers to use in evaluating individual health care interventions. The project will involve four or five employer participants out of the nine who participated in the HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY project. The multiyear project will compare self-reported data to actual claims data by episodes of care (e.g., medical mapping). The claims data will be used to pinpoint unit cost of care, while self-reported data will reveal productivity losses.

Expected outcomes of the ROI project are numerous. First, it will help participating employers identify diseases that need special attention. Second, the project will look at medical interventions by disease to discover which treatments field productivity increases and provide insight into the outcomes and costs of various interventions. Third, the project will enable participating employers to focus on the return on investment for their health care dollars. By dividing the cost of particular interventions into the potential savings in terms of treatment costs and worker productivity, participants can gain a better handle on the actual value of individual treatment methods.

Finally, the goal of the ROI project is to provide financially oriented data that can be applied to health care on a local, regional, and national basis. The ROI Business Model adds further credence to the overriding mission of the EHC, which is value-based health care purchasing in the United States.

EPILOGUE

Employers put the results of the 1998 HEALTHY PEOPLE/PRODUCTIVE COMMUNITY SURVEY to good use in 1999, especially regarding the top three disease conditions discovered—allergy, depression, and diabetes.

In relation to allergies, employers have taken steps to educate employees and dependents on the differences between sedating and nonsedating antihistamines and their impact on productivity. Employers have also had their managed care organizations add nonsedating medicines to their formularies where lacking. The prevalence of allergies (affecting over one in four individuals) and their impact on productivity (average of 3.1 lost days) mean potential savings of over $1.2 million per thousand employees.

Depression was addressed by individual employers, who met with their mental health providers to review employer-specific results. Working together, they reevaluated their existing plans and examined possible resolutions, including how to transition terminal patients back to work after treatment. Recently, EHC started a pilot program in which it acted as a facilitator and educator, assisting employers in evaluating their wants and expectations for mental health services and giving providers the information they need to design and tailor their services. Potential savings per thousand employees: $787,000.

Employers have also met individually with their managed care organizations to evaluate diabetic patients' knowledge of the disease and their awareness of the availability of diabetic supplies. These meetings are enhancing patients' understanding of the disease and how to care for themselves, reducing potential complications, and improving productivity. Potential savings per thousand employees: $164,000.

Whether one views obesity as a disease itself or as a co-morbidity contributing to other disease states (i.e., diabetes, hypertension, etc.), the impact of obesity on worker productivity and absenteeism is substantial. More attention needs to be given to this area in the future, as resources currently devoted to disease treatments and benefits can also be linked to obesity.

Since receipt of the 1999 survey results in May 2000, EHC's employers and task force members have presented the two-year results both locally and nationally to providers, managed care companies, and benefit consultants, as well as to other employers and interested parties across the country.

The nine employers have individually met with their managed care companies to discuss their specific results, where feasible. Additional premium discounts have also been offered due to the employer-generated data.

On September 12, 2000, EHC and its employer-members met in a roundtable forum where 100% of all the managed care companies and their Medical Directors/Representatives came to discuss the two-year results and the impact therapies have had on employee productivity. Another forum is set for early 2001 to further evaluate the best outcomes that yield the least impairment to employee productivity. □

Special Thanks

The EHC gives special thanks to Schering-Plough Corporation for the generous, unrestricted educational grant that helped make this written publication possible. Thanks also to Schering-Plough and all the EHC employers and taskforce members for their time and support.

For more information, please contact the
EHC website at: **WWW.EHCACCESS.ORG**

MADE POSSIBLE BY AN UNRESTRICTED EDUCATIONAL GRANT FROM SCHERING-PLOUGH

Published by Managed Care Communications Inc., 245 Kenrick St., Newton, MA 02458. 617.244.3900.